A DESCRIPTIVE STUDY OF THE PERCEIVED VALUES OF THE AMERICAN RED CROSS AFRICAN AMERICAN HIV/AIDS INSTRUCTOR'S TRAINING COURSE

By

MARSHA KAY WILSON

Bachelor of Science
Central State University
Edmond, Oklahoma
1990

Master of Education
University of Central Oklahoma
Edmond, Oklahoma
1991

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A DESCRIPTIVE STUDY OF THE PERCEIVED VALUES

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TRAINING COURSE

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Thesis Adviser

Dean of the Graduate College

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INTRODUCTION

Since its initial recognition in 1981, the acquired immunodeficiency syndrome (AIDS) has become a global epidemic (Koop, 1987). By March 1987, nearly 42,000 cases had been reported from over 90 countries. Because of under reporting, however, these numbers did not reflect accurately the true incidence of AIDS worldwide. According to Koop (1987), the World Health Organization estimated that there were over 100,000 cases of AIDS throughout the world, with a large majority of these cases occurring in North America and Africa. By the end of the year, in 1987, an additional 300,00-500,000 cases of AIDS related conditions (ARC) and an estimated 5-10 million people world-wide had already been infected with the virus that caused AIDS, the Human immunodeficiency virus (HIV).

According to the Centers for Disease Control and Prevention (CDC), AIDS and other illnesses due to HIV infection had been the fourth leading cause of death since 1992 among United States women between the ages of 25 and 44. In this age group, the rank of HIV infection among African American women advanced from second in 1992 to first in 1993, and for White women, from sixth in 1992 to fifth in 1993 (Centers for Disease Control and Prevention, February 1995).

The Centers for Disease Control and Prevention stated (February 1995), "African American and Hispanic women made up 21 percent of the women in the United States. Nationally, more than three-fourths (77 percent) of the AIDS cases reported among women in 1994 occurred among African American and Hispanics. For adult and adolescent females in the U.S., the AIDS case rates per 100,000 population in 1994 was 3.8 for non-Hispanic Whites, 62.7 for non-Hispanic African American, 26.0 for Hispanics, 1.3 for Asian/Pacific Islanders; and 5.8 for American Indians/Alaska Natives. The AIDS rate for African American and Hispanic women in the U.S. was approximately 16 and seven times greater, respectively, than that for White women in the U.S." (p. 2).

As a result of the HIV and AIDS infection rates across the country, the CDC issued guidelines to reduce the risk of human immunodeficiency virus among health-care workers, emergency-response and public safety workers, and others who might have been exposed to HIV while performing job duties (Morbidity and Mortality Weekly Report, September 1994). The guidelines developed by the Centers for Disease Control regarding HIV and AIDS were utilized by state agencies to develop protocols to implement programs and provided a safer working environment for employees. Each state agency was required to maintain a data base regarding the infection rates and modes of infection of HIV and AIDS and other communicable and chronic diseases. The maintenance of these types of data bases were mandatory to receive federal funds. The numbers were submitted to the CDC were compiled and were shared with other agencies across the country (Morbidity and Mortality Weekly Report, 1994).

According to the Morbidity and Mortality Weekly Report (1993),

> In local, state, and territorial health departments reported 58,5538 cases of acquired immunodeficiency syndrome among racial/ethnic minorities to the CDC. A total of 38,544 (66%) cases were reported among African American, 18,888 (32%) among Hispanics, 767 (1%) among Asians/Pacific Islanders, and 339 (1%) among American Indians/Alaskan Natives. These cases represented 55% of the 106,949 AIDS cases reported in the United States in 1993. (p. 644)

According to the Oklahoma State Department of Health (1999), the *majority* of the HIV and AIDS infected individuals had been reported as living within the urban areas of Oklahoma at their time of *initially* testing positive for HIV and being diagnosed with AIDS. Every region of the state in Oklahoma had cases of HIV and AIDS. Therefore, every section in Oklahoma had felt some impact of the disease. Although many more Whites have been reported than any other racial/ethnic group, African Americans had experienced the greatest impact, with 2 to 2 ½ times the rate of infection per 100,000 population.

The Oklahoma State Department of Health (1999) explained while the death rates of HIV had decreased in HIV infected individuals, from 1994 to 1998, HIV was still the leading cause of the death for all males ages 25-44. Although HIV was not the leading cause of death for any racial/ethnic group or age for females, it was the second leading cause of death for African American females ages 25-34. Through June 1999, 3,972 persons known to be HIV infected were currently living in Oklahoma. This calculated to a statewide prevalence rate of 126 per 100,000 citizens. Since 1981, a total of 5,441 cases, combined HIV and AIDS, had been reported. African Americans had been disproportionately affected by HIV/AIDS and STD surveillance data suggested they were still at risk for HIV exposure.

Background of the Study

According to the Centers for AIDS Prevention Studies (CAPS) (1995), many African American populations are at high risk for HIV infection, not because of their race or ethnicity, but because of the risky behaviors they may engage in. CAPS believed it was not who one was are, but what one did that put one at risk for HIV infection. CAPS further explained that the incidence of HIV in the African American community is disproportionately high. During the surveillance year of 1994, African Americans accounted for 33% of the total AIDS cases in the United States while comprising only 11% of the United States population.

According to Chavez (March/April 1995), the incidences of infection among African Americans and Hispanics had been linked to socioeconomic conditions, educational factors, lack of access to health care, cultural differences, and behavioral factors. Chavez further explained how the issue of distrust, as it related to health care, stemmed from the community's tragic involvement in the deadly syphilis study which involved hundreds of African American men. During this study, the government withheld the drug to cure the disease in an effort to observe the progression of the disease for more than 20 years. As a result, many African Americans believed they had been cursed by bad blood, when in reality, they were being used as test subjects.

Chavez (March/April 1995) stated, "the African American community's experience with federal institutions suggested that getting an African American to buy into prevention messages will be extremely difficult. The reasons were due to cultural attitudes and behaviors that were considered to be acceptable" (pp. 16-18). Chavez

explained that many African Americans tended to base much of their identity on their position within the group and attach significant value to personal creativity and freedom. This could have been further interpreted as African Americans from lower income brackets had developed an attitude and lifestyle that they had "nothing to lose" lifestyle and indulged in risky behaviors.

According to Cohen (1990), "minorities, particularly African American and Hispanics, are disproportionately affected by STDs. This could have been attributed to lack of access to health care and exposure to STDs which made minorities more vulnerable to STDs" (p. 87). He further explained the high incidence of HIV and AIDS could also have been attributed to minorities engaging in unprotected sexual behavior.

Thomas (1994) explained,

> The implications for people with HIV were clear. Life expectancy of African Americans after an HIV-positive test result was as much as three times shorter than that for White Americans. The reason was not that African American are more susceptible to the virus. But, rather African American were less likely to have insurance, to seek preventive health care, and to be tested for HIV before symptoms develop. So, all things being equal, the biology of HIV was no different for African Americans than any other group, it was due to race-specific health considerations. (p. 30)

The issues described in this section led to the development of health education programs by the American Red Cross to decrease the incidence of this deadly disease.

Principles for HIV/AIDS Prevention Messages

There are several principles of program development health educators should take into consideration when developing and/or conducting prevention messages. The following principles should serve as a guideline for future program development and

implementation for African American HIV/AIDS Programs. The following information was compiled from research from the Centers for Disease Control and the Department of Health and Human Services Public Health Service during 1990 and 1995.

- Principle Number One: Include behavior change models. These types of models can provide insights about how or why people choose their health behaviors and can help a program planner develop specific areas for educational intervention.
- Principle Number Two: Use performance standards. HIV, AIDS and STD educational programs lack a universally accepted standard for prevention messages. Therefore, a lack of continuity should exist to measure program effectiveness. If this were implemented, this could contribute to assuring a greater quality of instructional messages.
- Principle Number Three: Utilize social learning theories. Sound program development should be developed from social learning theories. It is important to focus on recognizing social influences, the difficulty of changing individual values and group norms, and building social norms.
- Principle Number Four: Use credible information sources. A dilemma often facing authors of new programs is deciding what is the accepted scientific belief about various HIV/AIDS and STD issues.
- Principle Number Five: Include individuals from the population the message is intended to affect. This will provide the program planner an insight of what the audience would be responsive to and how the message will be received.

- Principle Number Six: Incorporate components of successful programs. For instance, there are some programs with culturally specific messages that could be utilized to influence the credibility of the health educator. This includes racially-specific as well as messages that are focused on sexual orientation.
- Principle Number Seven: Assess the audience. Health education programs should be culturally relevant and age-appropriate. Knowledge of the audience can enhance the possibility of meeting the needs of the audience.
- Principle Number Eight: Use health promoting and objective material. The material used in the health education program should not be judgmental, include information that is offensive to the audience, or include information that can be seen as condescending.
- Principle Number Nine: Promote desired outcome. The sentinel objectives of the state is to reduce the rate of infection of HIV and other STDs. However, as a part of health education programs, educators fail to promote the outcome of the prevention message. Proper HIV prevention education is reality-based and acknowledges the value of both abstinence and risk reduction messages in preventing HIV infection. Health education programs should provide information on the results of health behavior risks associated with HIV transmission, prevention, disease symptom recognition, and accessing testing and health care.
- Principle Number Ten: Test message effectiveness. Evaluation of HIV program materials and content is important to determine if the material

meets the students' needs. It is important to conduct a pilot test or mock presentation. It is also necessary to conduct process evaluations to identify content weaknesses and strengths so that programmatic adjustments can be made.

American Red Cross HIV/AIDS Instructor's Course

According to the American Red Cross (1990), Americans had been living with AIDS since 1982, when the media began reporting heard about cases of rare concerns and illnesses in people whose immune systems were nearly destroyed. As a society, Americans lived with the impact that AIDS, a result of HIV infection, had on public health. As individuals, Americans lived with the impact that HIV/AIDS had on the personal lives of individuals, family and friends. If the spread of HIV and AIDS was to be limited, it was clear that people must be educated.

The goals of the American Red Cross HIV/AIDS Education Program were to help prevent the spread of HIV infection and to help people respond in reasonable ways to HIV infection itself as well as to the people who had the disease. The Instructor's Course furthered the goals of prevention and responded by training people to serve as Red Cross HIV/AIDS instructors for the community. The training equipped trainers with the basic skills necessary to give video-based HIV/AIDS community presentations lasting for either one hour, 90 minutes, or two hours. It also served as the foundation for other American Red Cross courses that trained instructors to reach youth minority populations, and people in the workplace.

The American Red Cross HIV/AIDS Instructor's Course prepared candidates to:

- Give basic facts about HIV infection, including AIDS, accurately;
- Respond appropriately to challenging questions from an audience;
- Feel more comfortable talking about facts related to sensitive topics like sex and sexuality and drugs and drug use;
- Present the facts sensitively to people who belong to diverse groups or communities;
- Present the facts without letting personal values, attitudes, and beliefs get in the way. (American Red Cross 1990)

The American Red Cross Basic HIV/AIDS Instructor's Course was comprised of eight chapters which presented information as shown in Table I:

TABLE I

HIV/AIDS INSTRUCTOR'S COURSE OUTLINE

Chapter	Title	Teaching Aids
1	Essential Facts About HIV and AIDS	Lecture, overheads, and handouts Liberal philosophical paradigm
2	More Facts About the Virus	Lecture, overheads, and handouts Liberal philosophical paradigm
3	More Facts About Transmission and Prevention	Lecture, overheads, and handouts Liberal philosophical paradigm
4	More Facts About Testing	Lecture, overheads, and handouts Liberal philosophical paradigm
5	More Facts About Blood Supply and Related Services	Lecture, overheads, and handouts Liberal philosophical paradigm
6	More Fact About Children With HIV Infection	Lecture, overheads, and handouts Liberal philosophical paradigm
7	More Facts About the Social Impact of HIV Infection	Lecture, overheads, and handouts Liberal philosophical paradigm
8	More Facts About First Aid, CPR, and Aquatics	Lecture, overheads, and handouts Liberal philosophical paradigm

Immediately following was a short section called "Key to Using the Facts Book" (1990).

Upon successful completion of this section, a candidate might attempt to receive certification in the African American HIV/AIDS Instructor's Course. As a prerequisite to taking the American Red Cross African American HIV/AIDS Instructor's course, candidates were expected to have completed the American Red Cross HIV/AIDS Instructor's course. Therefore, a potential Certified American Red Cross African American HIV/AIDS instructor were required to take an additional course to teach African Americans. This requirement required additional money and several extra days of training.

American Red Cross African American HIV/AIDS Instructor's Course

Since its creation, the African American HIV/AIDS Program had worked in partnership with other community-based organizations to help educate the community about HIV and AIDS. The American Red Cross supported the efforts of these groups by participating in many local and national activities, including health fairs, regional meetings and conferences, and national conventions (American Red Cross, November 1993).

The goal of the American Red Cross African American HIV/AIDS Program was to give African Americans sound, unbiased information that would enhance decision-making skills and support and increase self-protective behaviors. The program materials that accompanied the training manual emphasized behavior and behavioral skills rather

than medical information. The training focused on the use of culturally specific and age-appropriate language and communication techniques designed to increase the likelihood that the risk-reduction message would effectively reach African Americans. The program was developed by paid and volunteer staff for the National American Red Cross (1990).

The African American HIV/AIDS Training Course introduced skills to help the trainers:

- Facilitate video-based presentations ranging from one hour or less to four hours or more;
- Give culturally appropriate, age appropriate HIV/AIDS information to African Americans;
- Respond sensitively and appropriately to audience denial and challenges; and
- Feel more comfortable talking about adolescent life, and sensitive topics such as sex, substance abuse, and ethnicity. (1990)

According to the American Red Cross (1990),

> When information was shared in a culturally specific way, the cultural values and concerns of the target audience was used to construct and present HIV messages in ways the audience could readily understand and positively or appropriately respond. For instance, when working with African American groups, African American HIV/AIDS educators would use their knowledge of diverse African American communities and the language and cadences or vernacular to address culturally biased communication problems. (p. 2)

The American Red Cross believed instructors that participated in this program would look for and find ways to present culturally affirming HIV/AIDS education to African Americans and their communities. The Red Cross stated the African American

culture and its heritage were indelibly characterized by strength, resilience, spirituality, humor, creativity, and many other survival-oriented and success-oriented qualities. Culturally sensitive instructors could develop teaching strategies that recognized, embraced, and reaffirmed these characteristics to more effectively communicate with them (American Red Cross African American HIV/AIDS Program, 1990).

The American Red Cross explained, those who seek to work effectively in the area of HIV/AIDS education have to confront their own feelings and attitudes regarding the issues facing African American youth, families, and neighborhoods. It was important to become aware of how attitudes regarding the African American community drug epidemic and African American sexuality could affect one's ability to provide HIV/AIDS education. To achieve effective and nonjudgmental communication, HIV/AIDS educators had to examine their own biases and prejudices. HIV/AIDS educators must acknowledge the effects of racism has had on African Americans. As instructors go through this challenging and sometimes disturbing process, they could have become better able to identify and share commonalities and strengths to provide factual, empowering, life-saving information. The training style utilized during the training session included a combination of the progressive and behavioral philosophical paradigm.

The African American HIV/AIDS Instructor's Course is comprised of eight chapters which included:

Teaching Strategies

- Using Program Materials;
- Planning Presentations;
- Making a Presentation;

Psychological Issue-Special Topics

- How Teens May Perceive Risks of Infection;
- Stigma, Prejudice, and Discrimination;
- Discussing Sensitive Topics;
- Alcohol and Drugs; and
- Stressed Youth.

The following information is a description of the exercises used in the three-day training course which totaled 24 hours of training to train instructors in the African American HIV/AIDS Program which was developed in 1990. The specific theoretical issues and areas covered are also mentioned as they coincide with each of the following exercises shown in Table II.

TABLE II

TRAINING COURSE EXERCISES

Exercise	Areas Covered
The African American Response to AIDS	
Class breaks into small groups that discuss the difference between 1983 and the present with respect to knowledge and perceptions of AIDS. Groups are led to discuss origin theories, homosexuality, and the growing rate of HIV in the African American population.	Origin Theories; Views on Homosexuality; Seroprevalence Rates
Cultural Barriers and Enablers	
The following are covered: The use of statistics and teaching tool; birth control and genocide; poverty; stigma, discrimination, and denial; language and cultural communication. After discussion of these areas, groups make lists of labels, HIV/AIDS jargon, and judgmental language, and discuss with the whole class how these words are barriers to cultural communication.	Communication of Statistics; Genocide; Views on Homosexuality; Health Care Differences; Cultural Affirmation

TABLE II – Continued

Exercise	Areas Covered
Facts and Communication Skills Throughout the three days, 24 hours of training, a number of exercises, drills, and tough questions are covered with the class. Candidates take turns responding to real questions about HIV/AIDS. Answers must be communicated with the previous points in mind, and they must be more than just factually accurate. Each candidate's answer is reviewed by the class to discuss its appropriateness and effectiveness.	Theory of Reasoned Action: facts are communicated with cultural beliefs in mind.
Psychological Exercises Throughout the three days, there are a number of exercises that probe opinions, values, and the connection between how one thinks, feels, and acts. Candidates discuss their own personal opinions/values, defend opposite opinions/values, explore how to discuss areas they have opinions about without revealing their opinion in the discussion.	Personal Response and Communication Skills
Teaching Exercises: Transmission Candidates are taught a number of effective methods for teaching students to understand how HIV/AIDS is transmitted. Aside from standard methods, they are taught interactive exercises to use with students. One example is a sexual activity chart where students are asked to name certain sexual behaviors as "unsafe," "may be risky," or "safe." As students name activities, the instructor is taught how to encourage "safe" activities such as kissing, hand-holding, caressing, etcetera. In this way, students make the "safe" list the longest, showing them that they are not being told to stay away from sex, but to focus on their many options for safe sex.	Teen Communication
Looking at Drug Dependency Candidates are led through an exercise to explore personal reactions to addition and dependency.	Reactions to Drug Usage
Model Presentation A typical presentation using the adolescent video and course materials is modeled by the instructor trainer.	Reactions to Drug Usage
Condom Demonstration Candidates are taught how to demonstrate the proper way to apply/use condoms.	Teen Communication

TABLE II – Continued

Exercise	Areas Covered
Preparing for Specific Audiences Candidates work through an exercise where they prepare a presentation for different types of audiences which may include teens, parents, religious groups, culturally diverse groups, or gay and lesbian groups. This gives them the chance to demonstrate that teaching involves more than presenting facts.	Theory of Reasoned Action: Presentations will differ as audiences differ. In order to prepare for different audiences, one must understand them.
What if..... This is an exercise where adults look at a number of realistic teen scenarios where HIV transmission could occur. The purpose of the exercise is to compare the adult response to a situation to a typical teen response. They are taught to consider the adult response from the teen perspective. This is to help them teach specific refusal skills to teens as they practice moving from vague solutions to concrete behaviors to carry out the solution completely.	Teen Communication
Titles This is an exercise where candidates make lists of all the terms they can think of for sexual body parts, sexual activities, and sexually transmitted diseases. This is to help them to be prepared to hear and respond to terminology that might be common in their environment but they might not be comfortable with hearing or saying.	Cultural Communication
Teach backs Each instructor must prepare for two presentations: the first between days one and two; the second between days two and three. The first presentation is a practice "bridge" between the student video and the main points regarding transmission of the virus. The second "teach back" is longer and must introduce the topic and each of the five required key factual points regarding HIV/AIDS. Also, the candidate must answer questions from the group. Candidates are evaluated and critiqued by the trainers of the second presentation made by the candidates. They must successfully "pass" this teach back in order to become an instructor. The criteria for passing are based on the appropriateness and effectiveness of the candidates' communication style, as well as factual accuracy of information.	Integration of Concepts

African Americans and Health Education Prevention Activities

According to the Centers for Disease Control (1995),

> Preventing the spread of human immunodeficiency virus (HIV) and sexually transmitted disease (STD) required a comprehensive strategy composed of service delivery systems coupled with effective, sustained health education and health promotion interventions. These individual components of the prevention program must not operate in isolation, but must work together toward the well-being of the person at risk and the community as a whole. All education activities related to HIV/STD prevention should contribute to and complement the overall goal of reducing high-risk behaviors. (p. 5)

The Centers for Disease Control stated (1995),

> To be effective, an education intervention must also be culturally competent. Cultural competence began with the HIV/STD professional understanding and respecting cultural differences and understanding that the clients' cultures affected their beliefs, perceptions, attitudes, and behaviors. (p. 5)

According to Butler (1992),

> African Americans were a culturally distinct group of people bound by an ideological unity and a functional system of values and beliefs. Their cultural ethos and world view were inextricably woven together to give meaning and order to both their historical and contemporary experiences. An appreciation of these cultural elements was a prerequisite to understanding and interpreting their patterns of behavior. (p. 23)

Butler further explained (1992),

> In the areas of public health and welfare services, the impact of fundamental cultural differences and the consequences of cursory knowledge and understanding have been brought to the forefront in recent years. Far too often, lack of real knowledge and awareness of the varying lifestyle patterns and needs of populations resulted in inadequate service delivery, lack of compliance with expected norms and standards of behavior, and inconsistent or poor responses. Similarly, many factors that were peculiar to specific minority populations were often ignored in the development of programs for minority groups. (p. 23)

According to Butler (1992),

> The ethos of a people referred to the special characteristics that identified them as a group and set them apart from other groups. The African American ethos was spiritual. It derived from the African heritage and was maintained by shared experiences and common historical circumstances. These commonalities created a sense of oneness and unity among African Americans. It was this collective ethos that provides the common sentiments and emotional responses of the group. It was this same ethos that grounds African Americans and that has, at every point in time, caused men and women to rise up and take a stand, regardless of the consequences. This ethos was the spiritual connective force that gave an essence to the African American world view. (p. 29)

Butler further elaborated by explaining the African American's world view was manifested through the language, symbols, customs, values, and ideas of the people. Butler described Maulana Karenga's development of the seven foundational principles of the African American value system which included:

African Term	Meaning
Umoja	Unity
Kujichgulia	Self-determination
Ujima	Collective Work and Responsibility
Ujamaa	Cooperative Economics
Nia	Purpose
Kuumba	Creativity
Imani	Faith. (Butler, 1992, p. 30)

According to Rowell (1995),

> Knowing who one's audience is, their levels of knowledge and experience was critical to success in training. One would not speak to a room of health care professionals the same way one would to a meeting of a parent-teacher association, or to an audience of elders as you would to junior high school children. It was necessary to know one's audience and how to effectively communicate with them before one conduct HIV/AIDS training programs. (p. 42)

This was crucial to avoid perpetuating years of discrimination and distrust.

The idea of discrimination was not new. It has had implications in the lives of African Americans for many years. Connely (1968) believed the widening gap between the health status indices for African Americans and Whites was due to the frequent denials of adequate health care and being subjected to poor living and working conditions in this country. Connely also believed there have been negative effects of discrimination upon the health status of African Americans. In more recent years, the feeling of discrimination had lead to complex issues regarding minorities and HIV and AIDS.

Historically, African Americans had struggled with mixed feelings about AIDS. According to the American National Red Cross (1990),

> Initially, many believed HIV and AIDS was not a *real* problem for African Americans. Many believed the epidemic was a racist ploy, or possibly the result of germ warfare that went wrong. Many African Americans were still angry and hurt about early theories concerning the origin of the virus and were deeply concerned about the ongoing discrimination being suffered by Haitians and Africans. Additionally, many have struggled to accept the idea that African Americans were drug abusers and were active homosexuals and bisexuals. (p. 7)

The multiple needs of the HIV-infected population required a wide range of skilled personnel, including: physicians, nurses, physician assistants, dentists, eye doctors, psychologists, social workers, counselors, case managers, home health care workers, nutritionists, pharmacists, and patient advocates. With increasing numbers of HIV-infected patients, however, these providers were severely constrained by limited capacity and resources (El-Sadar, & Oleske, 1994). Prevention strategies were also needed to help decrease the incidence of HIV and AIDS.

Prevention Programs That Work For At-Risk Populations

The Centers for Disease Control convened a panel of 13 experts to synthesize existing research designed to reduce the risks of contracting sexually transmitted diseases. The experts identified 17 research studies that met the following criteria:

- Studied evaluated a HIV/STD prevention program; and
- Studied measured reported sexual behaviors and health outcome which included STD rates, pregnancy rates and birth rates.

It was determined that some of the programs that had positive effects had multiple common characteristics. Those characteristics included:

- Programs targeted at specific risk behaviors such as having unprotected sex;
- Implementation of social learning theory;
- Reinforcement of norms against unprotected sexual intercourse;
- Programs that practiced communication skills to help with refusal and negotiation; and
- Media influences that pressured at-risk individuals from participating in unhealthy sexual practices which could lead to HIV infection.

The results of the evaluation conducted by the set of experts have been accepted to be published in peer-reviewed journals (Public Health Report, 1994).

Statement of the Problem

Despite the American Red Cross African American HIV/AIDS Instructor's course, the prevalence of HIV/AIDS still persists in the African American community. Therefore, the perceived value of the instructor's course was studied to attempt to gain an understanding of what could be done or if anything could be done to decrease the incidence of HIV/AIDS in the African American community.

The Purpose of the Study

The purpose of this study was to investigate and obtain perceptions of the value of the American Red Cross African American HIV/AIDS Instructor's course from the trainer and the participants of the course. Within this study, insight into the strengths and weaknesses of the American Red Cross African American HIV/AIDS Instructor's course was emphasized. Additionally, suggestions to improve the course were developed for future use.

Research Questions

The following research questions have been identified as a foundation for this study:

1. Should professional health educators that were already certified American Red Cross HIV/AIDS Instructors be required to participate in the American Red Cross African American HIV/AIDS Instructor course to teach African Americans? Why or why not?

2. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the strengths and weaknesses of multicultural emphasis?
3. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the appropriateness of multicultural content and activities and objectives?
4. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the need for this course to have been required for all certified ARC HIV/AIDS instructors?
5. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding recommendations for improving the multicultural dimensions of the course?

Limitations of the Study

The study's limitations consisted of the usual limitations associated with surveys plus a few limitations associated with specific problems of the study's population (Key, 1995). The following limitations were identified:

- The study was limited to individuals that completed the American Red Cross HIV/AIDS Instructor's Course and the American Red Cross African American HIV/AIDS Instructor's Course within the past three years;

- Some participants may have been excluded from the study due to change of addresses without the benefit of forwarding addresses;
- The instrument's reliability coefficient was not available by the United States Department of Health and Human Service Public Health Service at the time this study was initiated;
- The respondents might not have honestly answered; and
- The study was only directly generalizable to health educators of the American Red Cross Program that provide HIV/AIDS education in the African American Community.

Assumptions of the Study

The primary assumptions of this study included the following list:

- The respondents honestly answered.
- Participants who did not participate did not negatively bias the results of the study.
- Including participants beyond the three years utilized in the study would not change the results of the study.
- Learning was an on-going process of life.
- Experiences garnered through completing the American Red Cross African American HIV/AIDS Instructor's course were similar.
- Every graduate of the American Red Cross African American HIV/AIDS Instructor's course would be willing to participate.

- Graduates from the American Red Cross African American HIV/AIDS Instructor's course that participated in the focus would be able to articulate their perceived values of the course.
- Each graduate of the American Red Cross African American HIV/AIDS Instructor's course have conducted at least one seminar to a predominately African American audience.
- Each graduate of the American Red Cross African American HIV/AIDS Instructor's course plans to maintain their certification by conducting programs to predominately African American audiences.
- The instrument utilized was both reliable and valid based on development and use by the United States Department of Health and Human Services Public Health Services which was federally funded.

Delimitation

This study was not designed to prove that the American Red Cross African American HIV/AIDS Instructor's course was more effective than any other HIV/AIDS training course. It attempted, rather, to present, through language the participants perceived values of the program and to identify strengths and weaknesses of the training program.

Outcomes of the Study

The researcher gained knowledge regarding the perceived values and learned the strengths and weaknesses of the American Red Cross African American HIV/AIDS

Instructor's Training Course. The researcher expected to learn information the American Red Cross could use to improve the African American HIV/AIDS instructor's course. The researcher planned to give the results of this study to the American Red Cross for consideration of program improvement.

Definition of Significant Terms

The principle investigator of this study considered multiple descriptions of terms and created operational definitions based upon the ideas of research-oriented data as it related to HIV and AIDS.

Acquired Immunodeficiency Syndrome (AIDS) – Defined as a disease in which the body's immune system breaks down. The immune system fights off infections and certain other diseases. Because the system fails, a person with AIDS develops a variety of life-threatening illnesses (CDC, August 1994).

African American – Defined as an individual that was considered to be an American citizen classified as Black. According to Millner (1999), the term African Americans were American Blacks of African descent. The term African American was utilized interchangeably with the term Black person or people in material presented in Chapter I.

Age Appropriate (Program) – Defined as a tailored program which has been developed to meet the needs of a specified age or age range. This has been done to take into account the basic developmental needs of a specified population.

American Red Cross – A non-profit organization whose mission is improve the quality of human life, to enhance self-reliance and concern for others; and to help people

avoid, prepare for, and cope with emergencies. It accomplished this through services that have been governed and directed by volunteers and have been consistent with its congressional charter and the principles of the International Red Cross. Those principles were identified as: Humanity; Impartiality; Neutrality; Independence; Voluntary Service; Unity; and Universality (American Red Cross, 1990).

AIDS Related Complex (ARC) – Defined as a term given to diseases that caused the death of individuals infected with HIV.

Cultural Competence – For the purpose of this document, cultural competence is defined as the capacity and skill to function effectively in environments that are culturally diverse and that are composed of distinct elements and qualities (CDC, 1995).

Cultural Sensitivity – Defined as understanding and appreciating cultural distinctions. Such understanding took into account the beliefs, values, actions, customs, unique needs of distinct population groups (American Academy of Pediatrics, 1999).

Human Immunodeficiency Virus (HIV) – Defined as the virus that causes AIDS. It has been known as the strongest known risk factor for the progression of tuberculosis from infection to disease. It has been classified as a retrovirus consisting of a central ribonucleic acid (RNA) surrounded by coats of virus-specific protein. In HIV-infected persons, the immune system recognizes the virus specific protein as foreign material and produces antibodies that are directed against this material. This was accomplished through complex mechanisms involving the white blood cells and the virus (CDC, 1993).

Multicultural – Defined as reflecting diverse cultures. According to Gorski (1999), the term multicultural took into account practical steps to promote understanding and respect for one another's culture. The term promoted cultural diversity. Gorski

further explained that it was a transformative movement in education which produced critical thinking. It was not just a change of curriculum or adding an activity. It was a movement which called for new attitudes, new approaches and new dedication to laying the foundation for the transformation of society.

Pneumocystis Carinii Pneumonia (PCP) – Identified as a lung infection (Prevention PCP, July, 1995).

Prophylaxis – Defined as a prevention method or treatment (Prevention PCP, July 1995). Prophylaxis have been used to prevent the spread of diseases and/or alleviate the discomfort of symptoms associated with sexually transmitted diseases such as HIV. This included medicine treatments. This also included condoms or dental damns which have been used during sexual intercourse and served as a barrier to prevent exchanging body fluids.

Sexually Transmitted Disease (STD) – A disease that had been contracted by means of sexual intercourse which includes: genital to genital sex, mouth to genital sex, and anal sex.

Organization of the Study

This study consisted of five chapters. Chapter I included an introduction. background of the study, statement of the problem, the purpose of the study, the research questions, assumptions and limitations of the study, outcomes and benefits and definitions of significant terms.

Chapter II contained a review of relevant literature. The review of literature focused on books, journal articles, manuals and materials related to HIV and AIDS. This

chapter also included information pertaining to the differences of HIV and AIDS, the modes of transmission, symptoms, testing information, statistics, treatment, universal precautions, high risk populations and the philosophy behind the African American HIV/AIDS Education Programs in an effort to educate minorities.

Chapter III described the methodology of the study, including the rationale for implementing a qualitative and quantitative method of inquiry. This chapter also described to participants used in the study. Additionally, a detailed explanation of the data analysis procedures was presented.

Chapter IV reported the findings, including the data gathered through description and exploration, of essential themes that emerged from the conversations with the participants in the study.

Chapter V presented the conclusions and recommendations for further practice and research derived from the analysis process.

CHAPTER II

REVIEW OF LITERATURE

People have become afraid of AIDS, but fear comes from not having information. If we're going to stop the spread of disease, we've got to work together and learn together.

-Dr. Lorraine Hale, MD (CDC, 1991)

The Need for HIV/AIDS Education

A study was conducted in 1989 assessing knowledge and behavior regarding AIDS. This study indicated AIDS was not an issue of concern. The study established the major strategy for preventing the spread of HIV/AIDS would be public health education. It was established that educational efforts should focus on dissemination of information, routes of transmission, and precautionary measures against the spread of the disease (Gray & Saracino, 1989).

The primary weapon against HIV was to provide education that promotes and influences healthy behavioral changes. According to Wilfert and Beck, AIDS Education Programs should have been initiated in a K-12 comprehensive health education curriculum. He believed a curriculum should have been taught in a developmentally appropriate grade-specific program by skilled educators who were ethnically and

culturally sensitive (Wilfert & Beck, 1998). It was crucial to get this information in schools because of the common factors of drug use and sexual activity often leads to the acquisition of the virus by adolescents and adults. Later, in this chapter, the statistical data explained how youth and adults, in Oklahoma have been impacted by this deadly virus.

According to Dr. Kelly (1992),

> Certain situational factors were associated with lapses in the avoidance of risk behavior, even in persons who were already knowledgeable and sensitized to HIV-risk behaviors. Excessive alcohol use or the use of other recreational drugs was associated with taking sexual risks. Affectionate feelings toward one's sexual partner have been associated with failure to comply with safer sex recommendations because condom usage is perceived as a connotation of lack of trust or intimacy. (p. 136)

Dr. Kelly believed behavior modification was the key to positively impact the incidence of HIV/AIDS.

Garrity stated (1991),

> Experience has clearly demonstrated that the simple provision of facts or promotion of abstinence was not enough. Human beings tended to be resistant to behavioral change in general, and when faced with changing sexual and drug-abuse behaviors, a stubborn resistance to behavioral change may have emerged. However, the lethality of HIV infection made individuals impatient with the slow, evolutionary pace of previous behavioral change processes. (p. 8)

According to AIDS Care, in order to become proactive about HIV/AIDS Programs, the prevention programs that are developed should target specific audiences. This should have included posters, pamphlets and media campaigns. This would have given targeted audiences the opportunity to broaden their knowledge-base about HIV/AIDS and provided them with messages that could have been viewed as culturally sensitive (Weatherburn, Hickson, & Reid, August 1998).

On a local level, according to the Oklahoma State Department of Health (January 1992),

> One out of every six adult males and one out of every 30 adult females who had syphilis was also HIV infected. In order to reduce the risk of HIV infection in Oklahoma, a multifaceted plan of action was necessary, including opportunities for education about sexually transmitted diseases, HIV antibody testing, and behavior modification and treatment. (p. 71)

The OSDH recognized the challenge of HIV prevention education. Service provisions have been complicated by the multiplicity of ethnic, cultural and racial diversity of Oklahoma. Recognition of these issues, which have been prevalent in Oklahoma, lead to implementing programs that promoted culturally specific HIV/AIDS programs.

Differences Between HIV and AIDS

HIV stands for human immunodeficiency virus, a retrovirus consisting of a central ribonucleic acid (RNA) surrounded by coats of virus-specific proteins. In HIV-infected persons, the immune system recognizes the virus protein as foreign material and produces antibodies that have been directed against this material. This was accomplished through complex mechanisms involving the white blood cells and the virus. People who have been infected with HIV became ill with opportunistic diseases and infections, had CD4+ counts of less than 200, or had CD4+ percentage of total lymphocytes of less than 14%, they were generally said to have AIDS (CDC, 1993).

AIDS stands for acquired immunodeficiency syndrome, a disease in which the body's immune system fought off infections and certain other diseases. Because the system failed, a person with AIDS developed a variety of life-threatening illnesses. AIDS

was caused by the virus called the human immunodeficiency virus, or HIV. No one could develop AIDS unless he or she has been infected with HIV (CDC, August 1994).

According to Nowak and McMichael, the interplay between HIV and the immune system turned out to be significantly more dynamic than most scientists would have suspected. HIV replicates prodigiously and destroyed many cells of the immune system each day. But this growth was met, usually for many years, by a vigorous defensive response that blocked the virus from multiplying out of control. Commonly, however, the balance of power eventually shifted so that HIV gained the upper hand and caused the severe immune impairment that defined AIDS (Nowak & McMichael, 1998).

Modes of Transmission

HIV could not be spread by casual contact (CDC, 1993). HIV has been spread by sexual contact with an infected person, by sharing needles and /or syringes (primarily for drug injection use) with someone who was infected and initially through transfusions with infected products. This was particularly prevalent during the initial onset of the disease in the 1980s. Babies born to HIV-infected women may become infected before or during birth, or through breast-feeding after birth (CDC, May 1994).

HIV has been spread through unprotected sexual intercourse, from male to female, from female to male, or from male to male. Female to female sexual transmission was possible, but rare. Modes of sexual intercourse include vaginal, anal, oral sex acts (CDC, August 1994).

With approximately one million Americans infected with HIV by the end of 1994, most of them through sexual transmission, and an estimated 12 million cases of other

sexually transmitted diseases (STDs) occurred each year in the United States. Therefore, effective strategies for preventing these diseases are critical. Refraining from having sexual intercourse with an infected partner was the best way to prevent transmission of HIV and other STDs. But for those who have sexual intercourse, latex condoms were highly effective when they have been used consistently and correctly (CDC, January 1995).

This protection was most evident from studies of couples in which one member was infected with HIV and the other was not. In a two-year study of discordant couples in Europe, 124 couples reported consistent use of latex condoms, none of the uninfected partners became infected. In contrast, 121 couples used condoms inconsistently. As a result, 10 percent of the uninfected partners became infected (CDC, January 1995).

HIV could have been transmitted through injection drug use when the blood of a HIV-infected drug user was transferred to a drug user who was not yet infected with HIV. Needles and syringes were the primary drug injection equipment involved in transferring HIV-infected blood between drug injectors. This transfer of HIV-infected blood occurs almost exclusively through the multi person use, or sharing of drug injection equipment. There were two types of drug injection activities that involved introducing blood into the needle and syringe. The first activity was to draw blood into the syringe to verify that the needle was inside a vein. The second, following drug injection, was to refill the syringe several times with blood from the vein to "wash out" any heroin, cocain, or other drug left in the syringe after the initial injection. Even if a tiny amount of infected blood was left in the syringe, the virus could have been transmitted to the next user (CDC, September 1993).

Fortunately, HIV was only found in some bodily fluids! The concentration of HIV per milliliter decreased from the top of the list down to the bottom of the list of bodily fluids listed below:

- Blood
- Semen
- Vaginal Secretions
- Breast Milk
- Saliva
- Tears
- Sweat
- Urine

According to an article entitled, "Where is HIV Found? How Can I Get It? What Are the Chances?," all of the aforementioned fluids have been found in every part of our bodies!

Preventing the spread of STDs required that persons at risk for transmitting or acquiring infections change their behaviors. The most effective way to prevent sexual transmission of HIV infection and other STDs was to avoid sexual intercourse. If this was not possible, individuals should consider not having intercourse with an infected partner. If a person chose to have sexual intercourse with a partner whose infection status was unknown or who was infected with HIV or other STDs, a new condom should have been used each time a couple engaged in sexual intercourse (CDC, 1993).

Comparison of U.S. AIDS cases reported among Blacks with those reported among all racial/ethnic groups, the major modes of HIV transmission among U.S. adults and adolescents reported to have AIDS are shown in Table III.

TABLE III

COMPARISON OF AIDS CASES

Transmission Category*	Cases Among U.S. Blacks	All Reported U.S. Cases
Injection drug use	39	24
Men who have sex with men	33	55
Men who have sex with men and inject drugs	6	6
Heterosexual contact	13	7

Note: *Percentages do not add up to 100% because some transmission categories have been omitted (CDC, October 1993, p. 2).

The only way to prevent the spread of this deadly disease was to be abstinent, maintain a monogamous relationship with someone who did not have the virus, and avoid drug usage particularly those drugs that promoted sharing needles (Gallo, 1996).

Signs and Symptoms

A person who was recently infected with HIV did not necessarily get sick right away. It could have been years before signs or symptoms of the disease might have appeared. In fact, some scientists said many individuals infected with HIV go through several steps or stages of infection (Branca, 1991).

Stage One-No Symptoms

At this stage, the person did not know that he or she was infected with the AIDS virus. The person appeared healthy and had no signs of illness. Blood tests may have

shown that antibodies were formed to fight the AIDS virus. But it could have taken months or even years for the antibodies to develop. In the meantime, the virus could remain hidden in the blood for as long as ten years without causing serious illness. However, from the time of infection, the person was able to pass the AIDS virus to other people (Branca, 1991).

Stage Two-Mild Illness

At this stage, something triggered the AIDS virus. It left the macrophages and began to attack the immune system. As the immune system was destroyed, the body weakened. The infected person's body might not be able to fight off germs that caused colds or other diseases. The person may have felt tired and lost weight. The person may have had a cough, diarrhea, fever during the day, or sweating at night (Branca, 1991).

Stage Three-Severe Illness

By this time, the HIV had already nearly destroyed the body's immune system. The body had a great deal of difficulty fighting off any germs. Germs which normally would not harm a person with a healthy immune system could attack the body of a person with HIV which could cause serious illnesses. The person often developed a lung disease, usually a kind of pneumonia. The AIDS patient could have developed Kaposi's sarcoma, a rare and often deadly kind of cancer. AIDS, itself, does not kill anyone. It has the infections and cancers that killed people (Branca, 1991).

Seroconversion illness had a viral syndrome that usually occurred within one month of becoming infected with HIV. It caused symptoms similar to the flu. Some of

those symptoms included: a sore throat, swollen glands, fevers, aches and pains. Many people had fatigue and rashes similar to those seen in glandular fever. In up to 20 percent of people, the symptoms were serious enough to consult a doctor, but the diagnosis was frequently missed. Even if an HIV antibody test was done at that time, it might not yet have been positive (AVERT, April, 1998).

Concurrent infections and syndromes have been found in patients with AIDS. Pneumocystis carinii was a protozoan which caused pneumonia only rarely prior to 1981. For persons with AIDS, it was a common pathogen. Kaposi's sarcoma also was frequently seen in sexually active immunodeficient homosexual males. This disease until recently was rarely observed, and only in elderly men of Mediterranean descent. Dark blue to purple brown lesions, usually on the extremities, weight loss, fever, night sweats, and fatigue were signs and symptoms observed in persons with Kaposi's sarcoma (Kinney, Packa & Dunbar, 1988).

Signs and Symptoms in Acquired Immunodeficiency Syndrome

The following information has been compiled to explain the signs and symptoms associated with AIDS.

- Wasting with lymphadenopathy
- Decrease of gamma interferon
- Lymphopenia (T cells)
- Decreased T4/T8 ratio
- T4 deficiency (HTLV-III destruction)
- Loss of immune memory

- Inability to recognize new antigens (DNZB)
- Increase in soluble suppressor factors
- Increase in number of B cells and associated hypergammaglobulinema
- Increase in circulating immune complexes
- Decrease in lymphokines
- Failure of B cells to respond to antigenic stimulation
- Malignant disease such as Kaposi's sarcoma, lymphoma, and Hodgkin's disease

Opportunistic Infections

The following information provided different types of opportunistic infections listed by several different classifications such as protozoan, viral and fungal and yeast infections commonly associated with AIDS which included:

Protozoan

- Pneumocystis carinii (pneumonia)
- Toxoplasma gondii
- Crytospodium (enteritis)
- Giardia lamblia
- Endamoeba histolytia

Viral

- Cytomegalovirus
- Herpes simplex virus

- Epstein-Barr virus
- Retrovirus (HTLV-1, HTLV-III)
- Adenovirus

Bacterial

- Mycobacterium avium (intercellular tuberculosis)
- Salmonella
- Listeria
- Chlamydia
- Neisseria

Fungal/Yeast

- Candida
- Aspergillus
- Cryptococcus Neoformans (meningitis)
- Nocardia (Kinney, Packa & Dunbar, 1988).

Testing

To know for certain if an individual has been infected with HIV, an individual must have his or her blood tested specifically for HIV infection, not just a "routine" blood test. The tests available to detect HIV infection were among the most accurate medical tests known. There were two separate tests for HIV. When both tests were used together, they were 99.9 percent accurate. One of the tests was called the Western Blot and the other is called the ELISA (CDC, Prevention Health Resources and NIH, June 1994).

Enzyme-linked immunosorbent assay (ELISA) was widely used to screen serum for the presence of anti-HTLV-III antibodies. The ELISA was almost 100 percent positive in AIDS Patients and high in healthy members of high-risk groups; it was 80 percent positive in intravenous drug users and 60 percent positive in sexually active homosexuals. ELISA was not, however, a test for AIDS but screened only for prior infections and an antibodies response to the HTLV-III virus. HTLV-III appeared to be, at least AIDS associated. The presence of HTLV-III antibodies could have been the result of AIDS (opportunistic infection) rather than its cause. HTLV-III infection required direct transfer of contaminated body secretions from one individual to another individual through intimate contact or direct transfusion (Kinney, Packa & Dunbar, 1988).

Testing for HIV-II antibodies was available through private physicians' offices and by state and local health departments. Testing was recommended for persons with risk factors for HIV-II infection and for individuals with illnesses that suggested they had an HIV infection such as an opportunistic infection (CDC, June 1995).

During the onset of the disease, there were two types of testing options. The first testing option was called anonymous testing which meant that absolutely no one knows an individual's name. Instead, an individual was given a code number. If this number was unknown to anyone, no one would ever know if the results of the tests were unless they were told by the individual that had been was tested. Many people utilized this type of testing because it controlled how or if they were going to tell someone they had been infected (Guzman & Gilea, 1995).

The second type of testing option was called confidential. This meant that the individual being tested gave his or her name. The test results became known by some of

the medical staff at the testing site. It also meant those results were placed in an individual's medical records at the testing site. Individuals that tested positive were linked with health care options (Guzman & Gilea, 1995).

Testing results usually took one to two weeks. There were some tests, if available, that may have provided results on the same day. A negative result meant HIV antibodies were found in the individual's body. However, an individual could still have been infected if they had been exposed to HIV within the last six months. Therefore, it was important to consider getting retested in a few months. A positive result meant that an individual's body was making HIV antibodies. This meant an individual has HIV. This did not mean the individual had AIDS or would get sick soon. Repeat tests should had to be taken to confirm the results. An intermediate result meant the results were unclear and a retest should have been taken (HIV Testing, 1996).

As late as May 2000, those same types of testing techniques were still used. However, new tests have been developed and approved to screen for the virus that caused AIDS in infected individuals. Those new tests have been identified in the following list:

- Home Testing Kit
- Amplicor HIV-1 Monitor Test
- Oral Diagnostic Test
- HIV Antigen Test
- HIV-1 Antigen Test for Blood Supply
- HIV Viral Load Test (Kubic, May 2000).

While these test have been approved for use by the general public, the percent accuracy was not available for each test. The testing mechanisms mentioned earlier, in this section, have been most widely used for testing purposes.

There were several benefits to being tested. If an individual had not been infected, the test could help an individual reduce their stress and anxiety level. An individual could also begin to take steps to reduce an individual's chances of getting infected in the future. If an individual has been infected, the test could allow an individual to start: treatment early, avoid spreading HIV by being extra careful not to engage in risky behaviors; avoid getting infected with other STDs which could have weakened the immune system, to inform others which might have included past and current sexual partners (HIV Testing, 1996).

Statistics

According to the Citizens Commission on AIDS, "the statistics for HIV and AIDS or suspected AIDS cases had been severely underestimated. Physicians often did not report cases of HIV-related illnesses and tended to under report those cases linked to HIV infection" (Citizens Commission on AIDS, February 1991, p. 46). This type of discrepancy had been reported across the United States, even in Oklahoma.

In the State of Oklahoma, the vision of the Oklahoma State Department of Health (OSDH) was to "Create a State of Health." The OSDH made a commitment to utilize its resources to protect and promote the health status of its citizens by preventing diseases, preventing injuries and assuring the conditions by which the citizens of the state could be

healthy (OSDH, 1996). One of the goals of the Healthy Oklahoma 2000 Sentinel Objectives was to address the issue of HIV and AIDS.

The Sentinel's objective for HIV infection was to confine the prevalence of HIV infection to no more than 400 cases per 100,000 people. The baseline data for this objective was from 1989. The incidence rate for that year was at a rate of 130-330 cases per 100,000 people. In 1994 the prevalence rate was 229 cases per 100,000 people (OSDH, 1996).

The tables on the next several pages were summary statistics from the Oklahoma State Department of Health. The first table included statistics of HIV and AIDS statistics in the state of Oklahoma. It also provided demographics such as ages of infected persons with HIV and AIDS, race and ethnicity, gender, and the numbers of pediatric, adolescent and adult cases.

The statistics found in Table IV were cumulative as of December 31, 1999. The number of HIV and AIDS cases were the largest among adults and adolescent populations with a total of 2,232 and 3,320 cases respectively. The largest age range was among the age group of 20-29 years of age with 903 individuals infected. The next largest age group of was 30-39 years of age with 880 individuals infected. This table also indicated that more Whites were infected with a total of 1,493 individuals and 517 African Americans were infected. Due to the population rates in the state of Oklahoma, African Americans have been infected disproportionately. The table also indicated that more males have been infected (Oklahoma State Department of Health, 1999).

TABLE IV

OKLAHOMA REPORTED HIV AND AIDS SUMMARY STATISTICS, CUMULATIVE AS OF 12/31/99

Cases	Oklahoma HIV			Oklahoma AIDS		
	Number	Deaths	(%)	Number	Deaths	(%)
Adult/Adolescent	2,232	98	4	3,320	1,863	56
Pediatric (<13 Years)	16	1	6	23	16	70
Total	2,248	99	4	3,343	1,879	56
Age	Number		%	Number		%
Under 5	11		0	13		0
5 - 12	5		0	10		0
13 - 19	80		4	17		1
20 - 29	903		40	719		22
30 - 39	880		39	1,591		48
40 - 49	276		12	685		20
Over 49	93		4	308		9
Unknown	0		0	0		0
Race/Ethnicity						
White	1,493		66	2,451		73
Black	517		23	540		16
Hispanic/Latino	90		4	117		3
Asian/Pacific Islander	8		0	12		0
American Indian/Alaska	128		6	220		7
Native	12		1	3		0
Unknown						
Gender						
Male	1,895		84	3,030		91
Female	353		16	313		9
Unknown	0		0	0		0
Pre-1987 Definition*	N/A			1,808		55
1987 Definition**	N/A			397		12
1993 Definition***	N/A			1,138		33
Total	2,248		100	3,343		100

Note: * = Original list of "opportunistic infections" established by Centers for Disease Control and Prevention (CDC), any one of which necessary for AIDS diagnosis; **= Additions to list, including AIDS-related dementia and wasting syndrome. Because all conditions are not necessarily infections, the new term for AIDS-defining conditions is "indicator disease"; ***= expands CDC definition to include: invasive cervical cancer, pulmonary tuberculosis, recurrent pneumonia, or a CD4+ lymphocyte count of less than 200 :l/dl or less than 14% of total lymphocytes. Update of definition applicable only to adults and adolescents aged 13 or older, continues to include the fact person exhibiting the disease must also be diagnosed as having HIV infection; Oklahoma State Department of Health, 1999.

Table V explained mode and rate of infection among adult and pediatric HIV and AIDS cases. This table included data from 1998 and 1999. This table indicated that men who had sex with men, individuals that used drugs intravenously, and men that had sex with and used injection drugs had been infected at a higher rate than those from other categories. The category with the least number of individuals infected with HIV and AIDS was from the category that included individuals that had received blood transfusions or tissue donations (Oklahoma State Department of Health, 1999).

Table VI included HIV and AIDS cases from the state of Oklahoma reported by county. The cases represented have been reported cumulatively though December 31, 1999. There were two counties with significantly higher HIV and AIDS infection rates. Those counties included Oklahoma County and Tulsa County. Oklahoma County had 1,248 AIDS cases and 855 HIV cases. Tulsa County had 955 AIDS cases and 606 HIV cases. There were several counties with fewer than 20 HIV and AIDS cases. However, those cases among other counties, when combined easily increased the number of cases to a significant number on a statewide basis. Every county in the state of Oklahoma has at least three known cases of HIV or AIDS (Oklahoma State Department of Health, 1999).

Table VII included information of Oklahoma HIV infection prevalence cases by county and included people living with HIV and people living with AIDS. The statistical prevalence was given at a rate of diagnosed cases per 100,000 through December 31, 1999. There were two counties with infection prevalence rates per 100,000 that were significantly higher than the other counties in Oklahoma. Those counties included Oklahoma County with a prevalence rate of 223 per 100,000 and Tulsa County with a prevalence rate of 203 per 100,000. The same counties have been identified as those with

TABLE V

OKLAHOMA REPORTED HIV/AIDS CASES
CUMULATIVE AS OF 12/31/99

Category	Oklahoma HIV						Oklahoma AIDS					
	Jan 98–Dec 98		Jan 99–Dec 99		Cumulative		Jan 98–Dec 98		Jan 99–Dec 99		Cumulative	
Adult/Adolescent Exposure	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)
Men who have Sex with Men (MSM)	131	45	90	46	1,075	48	112	44	62	48	2,010	61
Injection Drug Use (IDU)	39	13	23	12	282	13	33	13	13	10	367	11
MSM & IDU	27	9	11	6	215	10	30	12	13	10	417	13
Hemophilia/Clotting Disorder	0	0	0	0	9	0	0	0	1	1	45	1
Heterosexual Contact	31	11	25	13	230	10	22	9	8	6	206	6
Receipt of Blood Transfusion, Component, or Tissue	0	0	1	1	23	1	1	0	1	1	62	2
Risk Not Identified/Other	66	22	46	23	398	18	56	22	32	25	213	6
Adult/Adolescent Subtotal	294	100	196	100	2,232	100	254	100	130	100	3,320	100
Pediatric (<13 Years) Exposure												
Hemophilia/Clotting Disorder	0	0	0	0	3	19	0	0	0	0	5	24
Mother With/At Risk for HIV Infection	0	0	2	100	11	69	0	0	0	0	16	53
Receipt of Blood Transfusion, Component, or Tissue	0	0	0	0	0	0	0	0	0	0	1	3
Risk Not Identified/Other	0	0	0	0	2	13	0	0	0	0	1	7
Pediatric Subtotal	0	100	2	100	16	100	0	100	0	100	23	100
Grand Totals	294	100	198	100	2,248	100	254	100	130	100	3,343	100

Source: Oklahoma State Department of Health, 1999.

TABLE VI

OKLAHOMA HIV AND AIDS CASES WITH CUMULATIVE CASE REPORTS BY COUNTY*

COUNTY	HIV CASES	AIDS CASES	COUNTY	HIV CASES	AIDS CASES	COUNTY	HIV CASES	AIDS CASES
Adair	7	10	Haskell	3	7	Okmulgee	8	26
Atoka	**	7	Jackson	8	12	Osage	10	18
Beckham	4	10	Jefferson	5	4	Ottawa	5	11
Blaine	2	7	Johnston	3	**	Pawnee	3	6
Bryan	14	14	Kay	23	17	Payne	11	39
Caddo	24	20	Kingfisher	**	6	Pittsburg	16	36
Canadian	31	58	Kiowa	**	4	Pontotoc	11	19
Carter	17	22	Latimer	**	3	Pottawatomie	23	35
Cherokee	5	12	LeFlore	9	26	Pushmataha	**	6
Choctaw	6	7	Lincoln	4	10	Rogers	19	29
Cleveland	132	148	Logan	19	25	Seminole	8	10
Comanche	124	114	Love	**	5	Sequoyah	7	16
Cotton	**	4	Marshall	4	3	Stephens	12	12
Craig	3	9	Mayes	5	15	Texas	4	4
Creek	24	30	McClain	6	11	Tulsa	606	955
Custer	10	8	McCurtain	7	16	Wagoner	7	18
Delaware	7	8	McIntosh	5	13	Washington	8	15
Garfield	24	44	Murray	**	5	Washita	**	3
Garvin	4	3	Muskogee	34	52	Woodward	8	7
Grady	13	22	Nowata	**	6	Other Counties**	33	20
Grant	**	3	Okfuskee	3	10			
Greer	5	**	Oklahoma	855	1,248	Grand total	2,248	3,343

Note: As of December 31, 1999; *Resident of a county in Oklahoma at time of diagnosis; **Confidentiality concerns restrict releasing data for counties in Oklahoma which have two (2) or fewer cases.; Source – Oklahoma State Department of Health, 1999.

TABLE VII

OKLAHOMA HIV INFECTION PREVALENCE BY COUNTY OF RESIDENCE AT DIAGNOSIS

County	Living HIV+AIDS Cases	Prevalence Rate*	County	Living HIV+AIDS Cases	Prevalence Rate*	County	Living HIV+AIDS Cases	Prevalence Rate*
Adair	10	54	Haskell	5	46	Okmulgee	15	41
Atoka	4	31	Jackson	13	45	Osage	16	38
Beckham	7	37	Jefferson	7	100	Ottawa	5	16
Blaine	7	61	Johnston	4	40	Pawnee	7	45
Bryan	17	53	Kay	27	56	Payne	28	6
Caddo	32	108	Kingfisher	3	23	Pittsburg	30	74
Canadian	60	81	Kiowa	1	9	Pontotoc	19	56
Carter	21	49	Latimer	1	10	Pottawatomie	37	63
Cherokee	9	26	LeFlore	19	44	Pushmataha	3	27
Choctaw	9	59	Lincoln	8	27	Rogers	34	62
Cleveland	174	100	Logan	27	93	Seminole	13	51
Comanche	169	152	Love	3	37	Sequoyah	11	33
Cotton	3	45	Marshall	4	37	Stephens	17	40
Craig	11	78	Mayes	12	36	Texas	6	37
Creek	33	54	McClain	11	48	Tulsa	1,024	203
Custer	15	56	McCurtain	13	39	Wagoner	18	38
Delaware	11	36	McIntosh	11	66	Washington	13	27
Garfield	44	78	Murray	3	25	Washita	3	26
Garvin	5	19	Muskogee	59	87	Woodward	10	53
Grady	25	60	Nowata	5	50	Other Counties**	14	**N/A**
Grant	2	35	Okfuskee	11	95	Out of State	520	N/A
Greer	6	91	Oklahoma	1,337	223	Total***	4,112	131

Note: * = Per 100,000 Population, through December 31, 1999; ** = Confidentiality concerns restrict releasing data for counties in Oklahoma which have two (2) or fewer cases or the county of residence at first seropositive is not known; *** = Total includes out of state cases; Source – Oklahoma State Department of Health, 1999.

the highest number of individuals living with HIV and AIDS. Oklahoma County had 1,337 cases and Tulsa County had 1,024 cases of individuals living with HIV and AIDS (Oklahoma State Department of Health, 1999).

Table VIII included reported cumulative AIDS statistics in the United States through June 30, 1999. This table indicated adults and adolescent cases were among the

TABLE VIII

REPORTED AIDS SUMMARY STATISTICS
CUMULATIVE U.S. THROUGH 6/30/99

AIDS Cases	United States		
	Number	Deaths	(%)
Adult/Adolescent	702,748	418,058	59
Pediatric (<13 Years)	8,596	5,025	58
Total	711,344	423,083	59
Age			
Under 5	6,6721,924		1
5 - 12	3,564		0
13 - 19	120,773		0
20 - 29	319,947		18
30 - 39	183,195		46
40 - 49	75,266		25
Over 49			10
Unknown	3		0
Race / Ethnicity			
White	311,377		45
Black	262,317		36
Hispanic/Latino	129,555		18
Asian/Pacific Islander	5,133		1
American Indian/Alaska Native	2,034		0
Unknown	928		0
Gender			
Male	592,552		84
Female	118,789		16
Unknown	3		0
Exposure Category			
Men who have Sex with Men (MSM)	334,073		49
Injection Drug Use (IDU)	179,228		25
MSM & IDU	45,266		6
Hemophilia / coagulation disorder	5,243		1
Heterosexual Contact	70,582		9
Receipt of Transfusion	8,806		1
Mother with/at risk of HIV infection	7,828		1
Other / Risk not reported or identified	60,318		8
Total	711,344		100

Source: Oklahoma State Department of Health, 1999.

highest number individuals infected with AIDS as well as the highest number of deaths across the United States. The table also indicated that Whites were infected at a rate of 45% and African Americans at a rate of 36%. Table VIII also indicated that men were infected at a rate of 84% of the total population among individuals infected with AIDS, in the U.S. In the U.S. the exposure category was similar to the statistics found in Oklahoma. Men who have sex with men and injection drug users and men who combined having sex with men and used injection drugs were infected at a much higher rate that other categories represented in Table VIII.

Treatment

Treatments were available to slow the decline of immune system function. HIV-infected persons who have altered immune functions were at an increased risk for infections for which preventive measures were available (MMWR, 1997).

Proper management of HIV infection involved a complex array of behavioral, psychosocial, and medical services. Although some of these services, were usually unavailable in an STD treatment facility, other services, particularly medical services, were usually unavailable in this setting. Therefore, referrals to health-care facilities were often provided so that treatment could have been pursued as soon as possible (MMWR, 1997).

AIDS was primarily diagnosed by clinical evaluation of the patient showing severe immunodeficiency and a group of opportunistic infections. Laboratory data served to further evaluate and follow the condition. Once HTLV-III infection and integration

into human DNA occur, elimination and integration into human DNA occur, elimination of the viral blueprint through therapy was precluded (Kinney, Packa & Dunbar, 1988).

Studies from 1988 indicated, therapy was limited to protecting uninfected cells against the virus by using antiviral drugs and natural interferons. Despite the demonstration of an antibody against HTLV-III in the serum of AIDS and potential AIDS victims, the antibody was unable to effectively eliminate or neutralize the virus. Only after six months of infection was the antibody detected; this complicated the identification of carriers. The time lag between infection and detection allowed depletion of T4 cells and development of acquired immune deficiency. Once infected, the victim became an HTLV-III carrier even in the absence of symptoms of the disease (Kinney, Packa & Dunbar, 1988).

The advents of a new generational of antiviral drugs and the wide spread availability of tests for measuring levels of the virus in the blood have opened several pathways regarding the treatment of HIV disease. HIV-infected people may benefit more in the long run from some of the additional insights into the long run from some of the additional insights into the nature of the disease that those drugs and the diagnostic test provided. The powerful activity of the drugs and the measurements provided by the test permitted scientists to better understand what happened in the body. This included how quickly the virus was being produced, where it came from, and how it responded to drugs. This information in turn rapidly lead to the development of new strategies which go beyond the suppression of the virus (Project Inform, 1994).

In 1995, a pharmaceutical research study indicated that 34 new drugs and vaccines were discovered. The new therapies included two anti-cancers, four anti-infectives, 18

antivirals, two immunomodulators, four vaccines and two gene therapy vectors. The Food and Drug Administration (FDA) gave marketing approval for at least two of these medicines (Mossinghoff, 1995). Without these drugs, patients could expect to encounter a number of diseases and opportunistic infections.

Pneumocystis Carinii Pneumonia (PCP) was the leading cause of death among AIDS patients in 1995. It was a once rare lung infection. The organism which caused PCP had been commonly found in the environment. However, it became destructive in people with weakened immune systems. The first major symptom was a dry cough and shortness of breath accompanied by fatigue and shortness of breath. More than 80% of people with HIV could have expected to develop one or more episodes of PCP unless they used prophylaxis (Project Inform, 1995).

The Federal Drug Administration has approved several different types of drugs since the onset of the HIV/AIDS epidemic. While these drugs have been approved for use and have been prescribed to individuals whom have been infected with HIV, they have not found a cure. But, rather, drug companies and scientists have developed drugs which can alleviate symptoms and infections which accompany HIV. The following drugs (Table IX) identified in this research paper have not been identified as exhaustive. but, rather as drugs that have been classified as recent treatment therapies.

TABLE IX

DRUGS CLASSIFIED AS RECENT HIV/AIDS TREATMENT THERAPY

Drug/Medicine Treatment Therapy	Antiretroviral or Antifungal	Adult or Pediatric and Opportunistic Infection
Ritonavir (Norvur)	Antiretroviral	Pediatric/HIV
Paclitaxel (Taxol)	Antiretroviral	Adult/Kaposi's Sarcoma
Nelinavir Mesylate (Viracept)	Antiretroviral	Adult and Pedicatric/Protase Inhibitor for HIV Infection
Lamin Vudine/Zidovudine (Combivir)	Antiretroviral	12 years +/HIV Infection
Keto Conazole (Nizoral)	Antifungal	Adult/Blastoplasmosis, Histoplasmosis, and Candidais
Itaconazole (Sporanox)	Antifungal	Adult oral solution/ Oropharangeal, Esophogeal and Candidais

Source: Federal Drug Administration, June 1998.

Occupational Exposure Among Healthcare Workers

Viruses have been considered an important and often forgotten component in the spread of contagious diseases. The advent of HIV/AIDS and the growing numbers of Hepatitis B Virus (HBV) infections combined to heighten the awareness of hygiene. It was crucial for people to understand the exposure to any bodily fluid could have resulted in exposure to a virus (American Federation of Teachers, 1993).

In the health-care setting, workers had been infected with HIV after having been stuck with needles containing HIV-infected blood less frequently, health care workers have been infected after infected blood got into the worker's bloodstream through an

open cut or splashed into a mucous membrane such as an eye or in the nose (CDC, May 1994).

Of the persons reported with AIDS in the United States through December 1994, 14,591 had been employed in health care field. These cases represented 4.8 percent of the 304,651 AIDS cases reported to CDC from whom occupational information was known (CDC, May, 1995).

The type of job was known for 13,785 (94 percent) of the 14, 591 reported health care workers with AIDS. The specific occupations were as follows: 1,287 physicians, 90 surgeons, 3,256 nurses, 365 dental workers, 283 paramedics, 2,011 technicians, 719 therapists, and 2,831 health aides. The remainders were maintenance workers with AIDS, including 1,015 physicians, 69 surgeons, 2,394 nurses, 275 dental workers, and 196 paramedics, were reported to have died (CDC, May, 1995).

Investigations of HIV and HBV transmission from health care workers to patients indicated that, when health care workers adhered to recommended infection-control procedures, the risk of transmitting HBV from an infected health care worker to a patient was small and the risk of transmitting HIV was likely to be even smaller. To minimize the risk of HIV or HBV transmission, the following measures were recommended:

- All health care workers should have adhered to universal precautions, including appropriate use of hand washing, utilizing protective barriers, and care in the use and disposal of needles and other sharp instruments.
- Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care

equipment and devices used in performing invasive procedures until the condition was resolved.

- Health care workers who performed exposure-prone procedures should have known their HIV antibody status.
- Health care workers who were infected with HIV or HBV should not perform exposure prone procedures unless they have sought counsel from an expert review panel and have been advised under what circumstances, if any, they may have continued to perform these procedures (Morbidity and Mortality Weekly Report, 1991).

High Risk Populations

As early as 1993, Non-Hispanic African Americans represented 30 percent of all reported AIDS cases in the United States, but made up only 12 percent of the U.S. population. While the total number of AIDS cases historically had been highest among Whites, racial/ethnic minority groups in the United States had always been overly represented in proportion to population size, and the numbers of ethnic/racial minorities continued to grow (CDC, October, 1993).

Though June 1993, 97,794 U.S. African Americans had been reported to have AIDS. More than 50,000 of those persons died. In 1992 alone, 15,897 AIDS cases among African Americans of all ages were reported to CDC (CDC, October, 1993).

Cumulatively through June 1993, CDC had received reports of 315,390 AIDS cases in the United States, with 51 percent among Non-Hispanics Whites; 31 percent among Non-Hispanic African Americans; 17 percent among Hispanic; 0.6 percent among

Asians/Pacific Islanders; and 0.2 percent among American Indians/Alaska Natives (CDC, October 1993).

In 1994, women with AIDS were infected through injecting drugs at a rate of 41 percent. Nearly as many were infected through heterosexual contact with an infected partner. An additional 19 percent were initially reported with no specific mode of exposure. Historically, when these cases were investigated, it was found that most of those women (66%) were exposed through heterosexual sex. Additionally, most of the women infected were African American and Hispanics respectively (CDC, 1995).

The HIV epidemic in children was closely related with the epidemic in women. (CDC, 1995) Unfortunately, many women discovered their positive HIV status during pregnancy or when a child had been diagnosed positively for HIV (Mesiwala and Parks, 1994).

In 1994, the CDC received reports of more than 5,500 cases among children. The children reported, during that time, were infected with HIV through perinatal transmission. This occurred during pregnancy, labor, and delivery, or by breast-feeding (CDC, July, 1995).

The Centers for Disease Control tracked HIV infection for AIDS through a number of surveillance programs. Information on the status of HIV/AIDS was critical to plan and evaluate prevention programs, to determine health care resource needs, and to better target services and care to those who were in need (CDC, July, 1995).

Alternative Instructional Programs

The Bilingual Education Act of 1968 became law as Title VII. This act, focused on the individuals that were considered to be educationally disadvantaged (Lucas and Katz 1994). According to Lucas and Katz (1994), if individuals were provided with programs that offered native language skills and native language instruction, individuals could have built a solid foundation for growth and development at an optimal level. The basis of the American Red Cross African American HIV/AIDS Program was developed upon the premise that African Americans would benefit by instituting a educational program to disseminate information about HIV and AIDS in a manner that would have been culturally specific. Thus, reducing the incidence of HIV/AIDS in the African American community. There have been several HIV/AIDS prevention programs that have been developed for African Americans and other racially and culturally diverse groups.

The American Red Cross has also developed culturally specific HIV/AIDS prevention programs for other culturally diverse groups such as Native Americans and Hispanics. These programs have been developed in an effort to reduce the incidence of HIV/AIDS in those populations by providing training opportunities for potential trainers to obtain information, become certified and disseminate information in those culturally specific populations.

Several nonprofit organizations and special interest groups have developed programs to address the needs of "special populations" as it related to educating individuals and groups that were at risk for infection of HIV. On the west coast,

programs have been developed that were racially, gender and sexual preference specific to attempt to address the needs of people that were at risk for infection. According to Guzman and Gilea (1995), "something had to be done to help support each other to stay safe and healthy (p. I)."

Philosophy Behind African American HIV/AIDS Programs

AIDS was not just a White homosexual male disease, as initially believed by society. Many African American Men, Women and Children have AIDS. And, just as AIDS affected us all, not everyone was at risk. And even those people who were at risk, could protect themselves if they took reasonable precautions. Being safe from AIDS was up to each individual. It was each individual's responsibility to protect themselves and those whom they loved (CDC, 1991). This could been done by implementing HIV/AIDS Education Programs.

Several community-based programs have been established in a response to the AIDS epidemic in the minority community. The goal of these organizations has been twofold: the dissemination of AIDS educational material, especially to high risk groups; and to achieve a modification in the lifestyles that increased the risk of exposure of the AIDS virus (Randolph, 1991). It was also important to provide programs that targeted certain populations to create the opportunity for change.

In Merriam and Cunningham, Rubenson stated, "when analyzing adult education and social change, it was important to question the extent to which the educational activities were connected to a broader social and political struggle" (Rubenson, cited in Merriam & Cunningham, 1989, p.61). The conflict paradigm fostered the idea that the

"greater good" of society is determined by the *majority* and then it was forced upon the oppressed or *minority* community as "for one's own good." The *majority* perceives this idea as helping those that were unable to help themselves for the betterment of society.

The African American HIV/AIDS Program was established in response to the conflict paradigm initiated by the majority. The African American HIV/AIDS Program initially established by the *majority* due to an obvious inability of the minority community to control the spread of the deadly AIDS virus. The African American HIV/AIDS Program had assumptions that individuals make up large and small networks or systems. Within these social systems or networks, individuals could have acquired information, form attitudes, and develop beliefs. Also within these networks, individuals can acquire skills and practice new behaviors.

The development of the African American HIV/AIDS Program attempted to influence specific behaviors by utilizing social networks to consistently deliver HIV risk-reduction educational programs. The program did not target specific African Americans, it targeted the entire African American community (American Red Cross, November 1993).

According to Rubenson,

> Those individuals working within the conflict paradigm approach questions of social change, inequality, mobility, and stratification, and hence adult education, from the standpoint of the various individuals and interest groups within society. Social equality was seen as an expression of the struggle for power, privileges, and goods and services that were in short supply. (Rubenson, cited in Merriam & Cunningham, 1989, p. 61)

According to the American Red Cross (1990), many African Americans saw themselves as poverty stricken, faced with limited economic opportunities, and suffering

from professional inequalities. Attitudes like these have made it difficult to educate the African American community about HIV/AIDS. Educators not only had to use their knowledge of diverse communities, including vernacular to address culturally based communication problems, they had to deal with their own biases and prejudices.

According to MacDonald, O'Brien and Pittman (1993),

> Messages must have been clear, concrete and explicit. There could be no hesitation in using the same words and expressions that the audience were accustomed to hearing. Messages must have been consistent and should use environmental context, desires and problems as the strategic base from which to build communication and interaction with the participants. (pp. 2-3)

While MacDonald, O'Brien and Pittman recognized the importance of targeted "grassroots" AIDS programs, they also recognized the importance of formal programs developed by organizations and institutions.

In partnership with the National Urban League and other African American organizations, the American Red Cross developed a culturally specific program, which included a course to train and certify instructors. The program was released in 1990. The program was designed to give African Americans' reality-based information that would have supported youth in making decisions that could have reduced their risk of contracting HIV.

The theme "Respect Yourself, Protect Yourself" was stressed throughout the program along with support materials. The award-winning video *Don't Forget Sherrie* portrayed the dangers that drugs, sex, and alcohol could represent for young people, adversely affecting their ability to make sound judgements. The emphasis was on

strengthening decision-making skills that would have promoted protecting young people from contracting HIV.

Other program materials reflected the rich and diverse heritage of the African American community. There are six African Proverb Posters, based on the illustrations of Damballah Dolphus Smith, a Washington-based artist, conveyed important HIV/AIDS messages in a striking visual format. Another poster was designed featuring Patti Labelle which urged African Americans to get the facts about HIV transmission (American Red Cross, January 1994).

Instructors in the American Red Cross African American HIV/AIDS Program, many of whom work for community-based organizations, reached people wherever they gather-schools, places of worship and social clubs. According to a 1991 survey, conducted by the American Red Cross, a majority or the presentations made were through street outreach with individuals who may be at risk (American Red Cross, January 1994). The American Red Cross developed relationships with several African American organizations to help combat the spread of the AIDS virus in the African American communities.

In addition to working with the National Urban League, to maximize outreach efforts in the African American community, the American Red Cross established a relationship with Alpha Kappa Alpha Sorority, Incorporated (AKA). This sorority was established in 1908 at Howard University as the premier Black Sorority. AKA has a sisterhood of more than 130,000 women.

The American Red Cross and AKA established an agreement to work together for four years to provide education in health and safety. The primary focus for AKA was to

provide HIV/AIDS education. This was attributed to the impact of the disease on the African American community coupled with the existing lack of knowledge in the African American communities.

As a result, Alpha Kappa Alpha Sorority, Incorporated sent representatives to become trained in the American Red Cross African American HIV/AIDS Program. The sorority distributed the information to statewide HIV/AIDS network coordinators within the sorority and has provided education programs across the United States to attempt to positively impact the African American community (American Red Cross, 1996).

It was important to improve the health status of the community by promoting healthy behaviors and changing those factors that negatively affect the health of a community's residents. A specific education intervention might have taken the form of persuasive behavior change messages or it might have been a skills-building effort. Whatever its form, an educational program such as the one being investigated would achieve its goal by changing the group's norms to improve or enhance the quality of health for the members of the population. The norms referred to could relate to condom usage, contraceptive usage, or sharing needles when injecting drugs. Those norms could also focus on early diagnosis and treatment of sexually transmitted disease such as HIV.

It takes time to change social norms. They cannot be changed quickly or at the same rate that knowledge acquisition or skills development could occur. Change could only occurs as a result of sustained, consistent intervention efforts over time (Acquire & Bellinger, 1992).

Nature of the Learner

Research indicates that individual learning styles vary, that all people do not learn in the same way. The book entitled, "Changing Work, Changing Workers: Critical Perspectives on Language, Literacy, and Skills (1997)," the researchers found that the presumptions of the learning styles of African American women described in the literature were not as accurate as originally expected. This impacted the training of that group. Oftentimes, trainers assume they know what they are doing because they "know the literature." However, it is much deeper than anyone could ever imagine. There are many complexities involved as it relates to the minority learner. Past, present, and future problems combined with the ethnicity of the learner can have a tremendous impact on the learner.

Of particular interest to multicultural education is research suggesting that learning styles may be related to ethnicity in some ways. On the basis of this, educators should be aware of behavior that is normative and acceptable in various ethnic and cultural groups. The practices of multicultural programs must be both responsive and adaptive to ethnic differences.

The social problems that ethnic and cultural group members experience are often regarded as a part of their cultural characteristics. Ethnicity is often assumed to mean something negative and divisive, and the study of ethnic groups and ethnicity often becomes the examination of problems such as prejudice, racism, discrimination, and exploitation. To concentrate exclusively on these problems when studying ethnicity creates serious distortions in perceptions of ethnic groups.

Among other things, it stereotypes ethnic groups as essentially passive recipients of the dominant society's discrimination and exploitation. Although these are legitimate issues and should be included in a comprehensive, effective multicultural curriculum, they should not constitute the entire curriculum. Although many ethnic group members face staggering sociopolitical problems, these problems do not constitute the whole of their lives. Nor are all ethnic groups affected to the same degree or in the same way by these problems.

Moreover, many ethnic groups have developed and maintained viable life-styles and have made notable contributions to U.S. culture. The experiences of each ethnic group has had significant unifying historical experiences and cultural traits. No ethnic group has had a single, homogeneous, historical-cultural pattern. Members of minority ethnic groups do not conform to a single cultural norm or mode of behavior, nor are ethnic cultures uniform and static.

The multicultural curriculum should also promote the basic values expressed in our major historical documents. Each ethnic group should have the right to practice its own religious, social and cultural beliefs, albeit within the limits of due regard for the rights of others. There is after all, a set of overarching values that all groups within a society or nation must endorse to maintain societal cohesion.

In our nation, these core values stem from our commitment to human dignity, and include justice, equality, freedom, and due process of law. Although the ethnic and cultural group membership should not restrict an individual's opportunity and ability to achieve and to participate, it is sometimes used by groups in power to the detriment of less powerful groups. Individuals who do not understand the role of ethnicity often find it

troublesome reality, one extremely difficult to handle. Multicultural curricula should help students examine the dilemmas surrounding ethnicity as a step toward realizing its full potential as an enabling force in the lives of individuals, groups, and the nation.

Students need a rich foundation of sound knowledge. The multicultural curriculum must enable students to gain knowledge and apply it to their lives. Facts, concepts, generalizations, and theories differ in their capability for organizing particulars and in predictive capacity; concepts and generalizations have more usefulness than mere collections or miscellaneous facts. Young people need practice in the steps of scholarly methods for materials, organizing information as evidence, analyzing, interpreting, and reworking what they find, and making conclusions. Students also need ample opportunities to learn to use knowledge in making sense out of the situations they encounter.

Ideally, service for African Americans should be provided in a variety of ways such as: through specialized clinics, through advisory services, through general practitioners and through local outreach workers. It is important that a range of services are integrated and accessible during evening and weekend hours. Additionally, it is important that those services are close to public transportation, have a pleasant atmosphere, and have a non-judgmental reassuring staff.

Programs such as the American Red Cross African American HIV/AIDS Programs have been deemed as successful because they have encouraged their trainers to provide training that meets all or most of the aforementioned criteria for successful program implementation. The American Red Cross also encourages using video tapes, games, exercises and other materials that are culturally appropriate.

There is no data available to address the value of the program on a long term basis which addresses' infection rates among participants after they have participated in the program. This is crucial and should be studied.

Communication Styles

In order to communicate effectively, HIV/AIDS educators must be sensitive to the diversity of the specific "culture" being targeted. It is important to remember that cultural sensitivity communicates respect for the diversity of African Americans. African American language is emotional and has a sense of animation, of life. Speakers are expected to make words come alive, to use tonal rhymes, symbolism, figures of speech, and personification in order to inspire the imagination (American Red Cross, 1990).

African Americans use language to touch their hearts, souls, and "funny bones." African Americans expect to "tell it like it is" or to "get real." As a survival measure, African Americans may talk openly about the pain and hardships of life, but prefer that messages are broken down simply and concisely without a lot of flowery, intellectual wordiness or retention (American Red Cross, 1990).

African Americans' communication style is often characterized by interaction between the speaker and the listener. Speakers evoke feelings with jokes or with tonal rhymes such as "we have been abused, misused, refused, and confused." Listeners respond with words and phrases such as "amen" or "you ain't never lied." This type of communication can take place in church or classroom settings (American Red Cross, 1990).

Among African-American, common sense and direct experience often carry more weight than "book learning." The voice of experience is perceived as the most real and concrete.

While the cultural characteristics of language and communication styles suggest that the ethnicity of the messenger may be important in determining the effectiveness of the message, not everyone who gives information to African Americans communities is an African-American. Those who are not will want to consider the vibrant, emotional, and rhythmic nature of African American Language, as well as the interactive nature of effective communication and select the most appropriate teaching strategies available to them.

Showing cultural sensitivity means being aware that each group or community holds its own sets of values, attitudes, and beliefs that influence how members understand the world. Cultural sensitivity should make one aware that some of the audience participating might express differing values and prepare an individual to respond in a reasonable, nonjudgmental way (American Red Cross, 1990).

CHAPTER III

METHODOLOGY

Introduction

This study was a qualitative and quantitative inquiry of the American Red Cross African American HIV/AIDS Instructor's course. The purpose of this study was to investigate and obtain perceptions of the value of the American Red Cross African American HIV/AIDS Instructor's course from the trainer and the participants of the course. This study determined the strengths and weaknesses of the American Red Cross African American HIV/AIDS Instructor's course. Additionally, a list of recommendations and suggestions for program improvement was developed for the course, for future use.

This study was designed as a descriptive inquiry of the American Red Cross African American HIV/AIDS Program. The data from this study was drawn from questionnaires that included information as it pertained to the materials and instruction of the program. Information was obtained for data analysis from focus groups that were comprised of graduates from the American Red Cross African American HIV/AIDS Instructor's course. This was done in an effort to obtain data to improve the quality of the American Red Cross African American HIV/AIDS Instructor's Course. Additionally, it

was anticipated that recommendations would be identified for improved program implementation.

Benefits of a Descriptive Study

A unique feature of qualitative work was the attention to features unattended by those who engage in quantitative studies, giving the researcher the flexibility of participating more actively in the research process. This active engagement allowed the researcher's personal signature to emerge, giving the study a voice (Eisner, 1989).

The researcher chose this particular method for a research project because the researcher wanted to dig beneath the more general evaluations of the American Red Cross African American HIV/AIDS Instructor's course to find the bedrock beliefs of those that have participated in the program. Through the use of thick description, a characteristic of qualitative research, the researcher hoped to present the findings of this study in a manner that would benefit the American Red Cross and ultimately society.

Method of Inquiry

According to the Centers for Disease Control and Prevention (April 1995), "if a program was to be evaluated, the degree to which the program was evaluated included targeting specific audiences to be examined" (pp. 13-14). Both qualitative and quantitative methods of data collection and evaluation have been useful. Qualitative methods afforded the target audiences an opportunity to express their thoughts, feelings, ideals, and beliefs. Examples of qualitative methods included informal interviews and focus groups. These methods were designed to assist the program staff in identifying

problems or gaps that may not have recognized. The researcher utilized quantitative methods to seek deeper understanding, validate and reinforce the data obtained by the quantitative inquiry.

Shavelson (1996) believed descriptive statistics should provide a picture of what happened in the study. More formally, the term descriptive statistics referred to a set of concepts and methods used in organizing, summarizing, tabulating, depicting, and describing collections of data. The goal of descriptive statistics was to provide a representation of the data that described, in tabular, graphical, or numerical form, the results of research. Without descriptive statistics, data would have been overwhelming and uninterpretable. This method of inquiry was utilized in the organization of the information obtained from the focus group participants.

Babbie (1998) described descriptive statistics as a method for presenting qualitative descriptions in a manageable form. Sometimes it was used to describe single variables and sometimes it was utilized to describe the associations that connect one variable with another variable.

Quantitative methods rendered statistical information to explain data in a numerical form. Examples included questionnaires and surveys. Quantitative methods were also used to provide numerical information about the incidence of HIV/STD disease. They were used to maintain data bases to compile information derived from program activities such as the number of condoms distributed and documented requests for services (CDC, April 1995).

The quantitative component of this research project included a survey that was mailed to the former graduates of the American Red Cross African American HIV/AIDS

Instructor's Course. The data collected would provide numerical information regarding the effectiveness of the program studied.

Babie (1998) described questionnaires as essential to and most directly associated with modes of social research. He described questionnaires as a document containing questions and other types of items designed to solicit information appropriate to analysis. He further explained that questionnaires were associated with survey research.

According to Finch and Crunkilton (1993),

> The questionnaire served as a useful purpose in gathering information about curriculum materials used and the educational setting. Questionnaires could be used to identify the teachers' and students' personal characteristics, such as age, occupational experience, teaching experience, and education. This kind of information was important when the curriculum developer wanted to determine how different participants reacted to the material after having received instruction. (p. 289)

Instrumentation

In this study, the researcher found a theme and a tool to interpret and evaluate the documents in the study. The tool used in this study could draw forth pertinent information and provide answers to the questions in this study. During the phase of soliciting materials to be used to analyze the American Red Cross African American HIV/AIDS Instructor's course, the researcher obtained a copy of a questionnaire utilized by the Centers for Disease Prevention, U.S. Department of Health and Human Services Public Health Services (see Appendix A). This tool was utilized by the CDC for quality assurance purposes to review materials.

The reliability coefficient was not available on the instrument used in this study and has been listed as a limitation for this study in Chapter I. It was believed that this

tool was both valid and reliable because it was devised by the federal government and utilized by federal, state, and county government agencies to measure health education programs.

The nature of a qualitative study did not aim to control variables in a lab-like setting, but rather attempted to highlight the complexities of this study (Eisner, 1991), the CDC's Quality Assurance tool helped the researcher to avoid any preset conclusions that may have existed prior to the beginning of the research project. The tool utilized was believed to be both valid and reliable as printed in the Guidelines for Health Education and Risk Reduction Activities Manual developed by the United States Department of Health and Human Services Public Health Service (1995).

The following information described the sequence of research events.

I. Preparation

1. Developed research study objectives. Sought and received approval from the Institutional Review Board of Oklahoma State University (see Appendix B).
2. Prepared a tentative questionnaire, based on the questionnaire used in the Guidelines for Health Education and Risk Reduction Activities Material Review Checklist which was developed by the United States Department of Health and Human Services Public Health Service. The questionnaire also included questions which addressed multicultural implications which were evident in the American Red Cross African American HIV/AIDS Instructor's course.

3. Identified population of graduates from the American Red Cross African American HIV/AIDS Instructor's Course by requesting the information from the Red Cross official responsible for records maintenance from the Oklahoma County Chapter.
4. Obtained permission from the American Red Cross to use graduates from the American Red Cross African American HIV/AIDS Instructor's Course (see Appendix C).
5 Obtained addresses of the graduates from the American Red Cross African American HIV/AIDS Instructor's Course.
6. Established mailing dates and prepared material for mailing.
7. Mailed the consent forms (Appendix D) and questionnaires Appendix A) to the participants with self-addressed, stamped envelopes to facilitate returning of survey items.
8. Mailed follow-up letters and questionnaires to the graduates that did not respond.
9. After the research questions and the questionnaires was sent to the participants and returned to the researcher unanswered, the researcher met with consultants and determined the first focus group should meet to answer the research questions. The research questions were validated by the Doctoral Committee and consultants prior to the beginning of the study.

II. Data Collection

1. Received data from participants in the study by mail.

2. Utilized individuals from the last graduating class as members of a focus group established to provide rich data about the research questions being studied. Each member was verbally solicited by the American Red Cross and by researcher to participate as a focus group participant in the study during the last session of their class in September 1999.

3. Participants solicited by the researcher completed a background questionnaire at the training session upon completion of the solicitation to participate (see Appendix E).

III. Data Analysis

1. Analyzed and tabulated data from the questionnaires received by the participants. The aforementioned data received were from the written questionnaires received from the participants.

2. Prepared questions for the focus group.

3. Focus group responses reviewed by the consultants which included a program evaluator/statistician and an epidemiological professional/medical doctor.

4. Conducted mock presentation of focus group to allow the researcher the opportunity to practice asking the questions developed for the focus group.

5. Analyzed the data obtained during the first focus group session.

6. The data obtained by the researcher were reviewed, for validity, by the dissertation consultants which included a program

evaluator/statistician and a epidemiological expert/medical doctor to ensure the data were interpreted properly.

7. After the data were analyzed and had received approval from the panel, the researcher explained the results obtained in Chapter IV.
8. The researcher met with the Doctoral Committee members to discuss the initial results obtained from the first focus group session. As a result, the Doctoral Committee recommended the researcher reconvene the first focus group to address unanswered questions from the first focus group session. This was done to gain greater insight into the results of the first focus group session.
9. Convened the second session of the first focus group. After the session was conducted, the researcher synthesized the data and reported the information obtained in Chapter IV.
10. Convened another focus group with new participants. This was done to gain insight into research questions developed as a result of meeting with the first focus group. The research questions have been identified in Chapter III in the section which addresses the format utilized during the focus groups.
11. Chapter IV was prepared. This chapter was composed of the analysis of the data obtained during the research project.

A copy of the questionnaire and the letter requesting the participants assistance in this study was provided in Appendixes A and D.

Research Sample

The participants of this study consisted of graduates of the Oklahoma Chapter American Red Cross African American HIV/AIDS Instructor's course. The participants in this study were graduates of the African American HIV/AIDS Instructor's course from the past three years which included 1997, 1998, and 1999.

The participants in this study were identified by an American Red Cross Representative. Each graduate, identified by the American Red Cross as a potential participant was contacted by letter requesting their participation. In addition to the letter of request to participate in this study was a copy of the consent form and the questionnaire with a stamped envelope to facilitate a higher degree of return of the questionnaire. The letters and questionnaires were sent to all graduates at their last known address. Initially, it was anticipated that there would be approximately 50 graduates from the course, in the last three years. However, the actual number of graduates was 37.

The questionnaires were sent to each participant and included all of the information except the return address and name of the respondent. Members, later to be identified as focus group members also completed the questionnaire. All graduates who could not be identified as respondents were sent an additional letter and questionnaire. It was also explained that each participant that responded to previous mailings should discard the added correspondence to avoid participants responding multiple times.

Focus Groups

The focus group participants were initially solicited by the American Red Cross Representative and by the Trainer of the American Red Cross African American HIV/AIDS Instructor's course. Then, the focus group participants were verbally, solicited by the researcher. The appeal to participate was conducted at the last class of the most recent seminar which occurred during September of 1999. Members were provided the opportunity to "sign up" to participate in the study. They were instructed that they would be receiving a questionnaire in the mail and they might receive a phone call asking them to participate in the focus group.

After the names were identified, the researcher called six participants to participate in the first focus group session established to give this study more strength. However, due to the time established for the focus group session, only four participants were able to attend the first focus group session.

The questions posed to the first focus group, initially, were to be developed after the initial questions were answered, received by the researcher, and analyzed by the researcher. After the questions were to be developed, based on the responses of the first questionnaire, the researcher planned to have dissertation consultants which included an Epidemiologist and a Program Evaluator/Statistician expert to review the questions to establish validity and reliability. After the questions were reviewed by the dissertation consultants, modifications were made.

Due to a poor response rate of the initial research questions mailed to the participants, it was determined that additional focus groups were needed to answer the

research questions rather than develop new questions. Lastly, the researcher conducted a mock focus group to decrease the possibility of the researcher demonstrating bias during the focus group session with the graduates of the American Red Cross African American HIV/AIDS Instructor's course.

However, after the questionnaires were received by the researcher, the researcher discovered all of the participants failed to return their responses to the researcher. After sharing this information with the dissertation consultants, it was determined to have the focus group specifically deal with the research questions of this study. The Program evaluator explained that it was crucial to have those individuals participating in the focus group to answer the research questions to obtain the data the researcher was striving to attain during the research process.

The dissertation consultants concurred with the researcher's Doctoral Committee Members that the questions developed were acceptable questions to pose to the focus group established for the research project. The researcher began contacting the participants and informed them of the meeting place and time.

The participants were not chosen to represent all who have already graduated from the American Red Cross African American HIV/AIDS Instructor's course. They were examples of recent graduates from the program. As such, they had potentially insightful stories to relate and experiences to share that were examined for "truth" as these individuals knew truth. This study looked for wisdom from those who have already completed the course. According to Casey (1993), "the principal value of oral history was that its information came complete with evaluations, explanations, and theories which were intrinsic to its representation of reality" (p. 13).

After the researcher met with the first focus group and convened a second session of the focus group participants, information was revealed which indicated another focus group should be established to answer questions raised from the first focus group's meetings. The researcher randomly selected six names from the last graduating class of the American Red Cross African American HIV/AIDS Instructor's Course. The researcher contacted those individuals to find out if they might be available to meet to answer the research established for their group. Three of the six participants were available to meet on the day established for focus group number two in a series of three focus groups. The third session was held and the results have been explained in Chapter IV.

Focus Group Procedures

Each participant in the focus groups answered a "Health Education and Risk Reduction Activities Quality Assurance Questionnaire" developed by the U.S. Department of Health and Human Services prior to the focus group meetings. All participants were assured of anonymity and were told that pseudonyms would be used in all of the data notes and the reporting of the data. The researcher asked the participants if a tape recorder could be used to assist the researcher in transcribing the focus group session. Two of the four focus group participants in the first session indicated they were uncomfortable being taped. Only one of the three participants in the second focus group indicated that the use of a recoding device would interfere with the participant's comfort level during the session. Therefore, a recording device was not used.

The researcher took notes on a laptop computer. The transcription of the notes was completed by the researcher to reduce the potential incidence of misinterpretation of notes taken to obtain data for the research project.

Enough flexibility was maintained during the focus group sessions for participants to have sufficient opportunities to "tell their stories" in ways that felt most comfortable for them. They were encouraged to draw upon their own understanding of how they saw and experienced the American Red Cross African American HIV/AIDS Instructor's course because of their status as graduates.

Prior to beginning the focus group's sessions, the participants introduced themselves and gave a synopsis of their professional and educational background. They also provided information regarding how long it has been since they graduated from the instructor's course and if they have made presentations since they completed the instructor's course. It was of prime importance for the participants to feel comfortable. Therefore, as much time as the participants needed was utilized in the early stages of questioning to obtain data for this study. McCracken (1988) stated, "the application of the social sciences to the study and improvement of contemporary life depend upon the intimate understanding of the respondent" (p. 10).

Format for Focus Group Sessions

This section described the format used during the focus group sessions. It has been subdivided into sections explaining what occurred during the focus groups.

Section One-Rapport: Beginning questions were of an introductory and rapport building nature.

- Talked about each individual's hobbies and free time activities.
- Listed three words that might be used to describe themselves so that someone would know the "real" person.

Section Two-Answer Research Questions: Focus Group Number One, Session Number One.

1. Should professional health educators that were certified American Red Cross HIV/AIDS Instructors be required to participate in the American Red Cross African American Instructor's course to teach African Americans?
2. What was the impact of the American Red Cross African American HIV/AIDS Instructor's course? This question was asked to facilitate personal stories from the participants.
3. What were the participant's perceptions of the American Red Cross African American HIV/AIDS Instructor's course with regard to the content of material covered regarding the multicultural aspects?
4. What were the strengths and weaknesses of the American Red Cross African American HIV/AIDS Instructor's course?
5. What suggestions could be implemented to improve the American Red Cross African American HIV/AIDS Instructor's course?

Section Three-Answer Research Questions: Focus Group Number One, Session Number Two.

- Each of the participants that mailed responses back to the researcher had the same responses. The participants were asked why they believed this occurred.
- The focus group identified several weaknesses evident in the American Red Cross African American HIV/AIDS Instructor's training course. But when asked if the focus group could identify recommendations for improving the multicultural dimensions of the course: The group indicated you would not make any changes. Why?
- None of the participants that participated in this research project returned answers to the research questions. As participants in this study, they were asked why they believed this occurred.
- What specific types of things could be done to correct the weaknesses identified in the first session?

Section Four-Answer Research Questions: Focus Group Number Two, Session Number One

- The participants were asked if they perceived the development of this course as going forward or backwards. Why?

Section Five-Program Material Review: This section allowed the participants to revisit the "Health Education and Risk Reduction Activities Quality Assurance Questionnaire" to see if the participants had anything they wanted to address that was not

previously addressed. The inventory included the following statements for the participants to use as a guideline to assess the materials used in the African American HIV/AID Instructor's course. Additional questions were added to address the multicultural aspects of the inventory. The items listed below were included in the questionnaire conducted prior to the focus group by the entire sample which included the focus group participants of this study:

1. Material was clearly introduced and states the purpose of the text to the reader.
2. Major points of text were summarized at the end.
3. Materials were brief, concise, and in the language or dialect of the target audience.
4. Materials were written at the educational and reading level of the target audience. Avoided jargon and technical phrases.
5. Materials used language and terms with which the target audience was comfortable.
6. Used active verbs and short, simple sentences, with one concept per sentence in short paragraphs.
7. Materials avoided or defined difficult words and concept. Examples were used to clarify.
8. Used terms consistently (e.g., "HIV" and "AIDS virus" were not used interchangeably).

9. Materials were straightforward and clear. (Did not use abbreviations, acronyms, euphemisms, symbolism, statistics, or anything else that could have caused confusion).
10. Text used line drawings if illustrations were included.
11. Illustration of anatomy showed position of organs within the whole body (gave relative size and location reference).
12. Text used lists, bullets, or illustrations instead of long discussions. Visuals (overheads, slides) were used to emphasize key points.
13. Text was underlined, boldfaced, or "boxed" for reinforcement.
14. The text dispelled myths, used acceptable channels, referred to value systems for reasons to change behavior or adopt a new perspective.
15. Materials provided a call for action.
16. The text illustrated manual skills from audience perspective.
17. The text provided reasons for changing behavior.
18. Materials provided current and accurate medical information.
19. Materials did not contain sexual preference or racial, gender, or ethnic bias.
20. Text offered alternative behaviors to the one(s) that put a person at risk.
21. Realistic and relevant examples were given.
22. The format of the text was not visually distracting.
23. Graphics were immediately identifiable, relevant, and simple. They reinforce text. (CDC, June 1990)
24. Effectiveness of multicultural emphasis.

25. Appropriateness of multicultural content and activities objectives.

26. Need for this course to be required for all certified American Red Cross HIV/AIDS instructors.

27. Recommendations for improving the multicultural dimensions.

The materials review checklist also included three sections that allowed the participants to provide a more personal verbal response. Those sections included: Comments on conclusion; Groups response to the facilitator; Overall suggestions and remarks; and Facilitator's comments. A copy of the questionnaire has been included in Appendix A.

After the completion of each of the focus group sessions, the researcher the clarified the participant's responses and made verbal accounts of what appeared to be the central themes identified by the participants to ensure accuracy of the information. Upon completion of the focus groups, the researcher began developing Chapter IV, Analysis of the Data.

Method of Analysis

According to Gallano and Neklek (1996), "categorical data, sometimes called nominal data, results when information has been described in terms of a set of mutually exclusive categories. This type of data could have been helpful in summarizing information obtained for evaluation purposes" (p. 99). The researcher used this method of analysis during the data analysis process.

After obtaining the data disseminated by the participants, it was necessary to review the information obtained to establish categories, patterns and central themes

expressed by the participants. In the early stages of analysis, the researcher placed information obtained on note cards. This was followed by organizing these cards into categories that seemed to have common content for data analysis purposes. The information shared by the participants unfolded in the fourth chapter of this study.

The data was organized and summarized by highlighting aspects of the data by using a frequency distribution. This was done to show a tabular arrangement of the score values on each item answered by the participants. The measure of central tendency used in this study was percent averages of each item asked of the participants in the questionnaire. This was done because the researcher wanted to describe the distribution of scores in the sample and draw inferences from the sample to the population of graduates from the American Red Cross African American HIV/AIDS Instructor's Course.

CHAPTER IV

ANALYSIS OF DATA

Introduction

The American Red Cross African American HIV/AIDS Program is a culturally specific prevention program whose goal is to provide minorities with unbiased information about HIV/AIDS. The program provides the American Red Cross instructors with Afrocentric skills and techniques to utilize during presentations to minorities. The presentations are prepared to be nonjudgmental and culturally specific.

The researcher saw an opportunity to investigate the perceived value(s) of the American Red Cross African American HIV/AIDS Instructor's course. The researcher also investigated the perceived strengths and weaknesses of this course as seen by the graduates of this course.

This study was designed as an evaluation of the American Red Cross African American HIV/AIDS Instructor's Course. Analyses were conducted to assess the perceived values of the course and identify the strengths and weaknesses of the course. This was accomplished by an evaluation of the instructor's course curriculum utilizing the Health Education Reduction Risk Quality Assurance Materials Review Check list. The focus groups were established and utilized to answer the research questions.

Lastly, to provide the reader with participation observation information, the researcher attempted to attend a presentation to observe a trained instructor from the American Red Cross African American HIV/AIDS Instructor's course. However, this did not occur as there were no presentations scheduled to occur within the time frame established by the researcher before completion of this research project. Several organizations were contacted in an effort to obtain participatory observation data.

The researcher contacted the American Red Cross, Urban League, City County Health Department of Oklahoma County, Oklahoma State Department of Health, Community Action Agency, Mary Mahoney Memorial Health Center, Planned Parenthood, and the Variety Health Center. As previously mentioned, no presentations were scheduled during the time the research project was conducted.

Statement of the Problem

Despite the American Red Cross African American HIV/AIDS Instructor's course, the prevalence of HIV/AIDS still persists in the African American community. Therefore, the perceived values of the American Red Cross African American HIV/AIDS Instructor's Course were studied to attempt to gain greater understanding of its effectiveness with the hope that the results could lead to improvements that could potentially decrease the incidence of HIV/AIDS in the African American community.

Purpose of the Study

The purpose of this study was to investigate and obtain perceptions of the value of the American Red Cross African American HIV/AIDS Instructor's course from the

viewpoint of the trainer and the participants of the course. The purpose of this study included an emphasis on the strengths and weaknesses of the American Red Cross HIV/AIDS Instructor's course. Additionally, the purpose was to gather data that would improve the course.

American Red Cross African American HIV/AIDS Instructor's Course Highlights

The goal of the course is to give African Americans information to enhance their decision-making skills and support behaviors that reduce the risk of becoming infected with HIV. The objective of the train-the trainer course was to prepare knowledgeable instructors who understand and are sensitive to the cultural and psychological issues raised by HIV infection, including AIDS. The course is constructed to share information in culturally specific ways. The cultural values and concerns of the target audience are used to construct and present messages in ways the audience can readily understand and respond to positively.

Questionnaire Results

The researcher sent the questionnaires out to each of the graduates and trainer. The researcher received the questionnaires, by mail, and started keeping a tally of the results on a master copy to keep track of the responses of the participants. The participants had more than two and one half weeks to respond. After approximately ten days went by, the researcher sent the letters of request to participate for a second time. The cut-off date was two days before the focus group was scheduled.

After the researcher received all of the questionnaires, by the specified date, the researcher was surprised that not one of the respondents answered any of the research questions enclosed with their letters. This issue will be addressed in another section in this chapter.

The inventory, mailed to each participant, included the following statements for the participants to use as a guideline to assess the materials used in the African American HIV/AID Instructor's course. Additional questions were added to address the multicultural aspects of the inventory. The following information has been represented by percentages of the sample population. The initial number of participants anticipated was 37. However, the number of actual respondents, by the deadline date of July 12, 2000, was 22 for a response rate of 59 percent.

An unusual phenomenon occurred. All of the participants marked the same responses on each question. All of the answers were the same. The focus group attempted to address this unusual occurrence.

The surveys indicated the participants believed the American Red Cross African American HIV/AIDS Instructor's Course met the *"Guidelines for Health Education and Risk Reduction Activities Quality Assurance Material Review Checklist's"* criteria for being acknowledged as "excellent"and therefore deemed as a quality program by the graduates of the course (see Table X).

The results indicated that each participant that responded believed the program was excellent as it related to its clarity in identifying its purpose. They indicated that the major points were summarized well. The materials were determined to be brief and the language was appropriate for the intended audience. The materials were not written in a

TABLE X

QUESTIONNAIRE RESULTS MEASURE OF CENTRAL TENDENCY IN PERCENTAGES

	Material Review Checklist	Excellent	Fully Successful	Needs Attention	Not Applicable
1.	Material was clearly introduced and stated the purpose of the text to the reader.	100%			
2.	Major points of text were summarized at the end.	100%			
3.	Materials were brief, concise, and in the language or dialect of the target audience.	100%			
4.	Materials were written at the educational and reading level of the target audience. Avoided jargon and technical phrases.	100%			
5.	Materials used language and terms with which the target audience was comfortable.	100%			
6.	Used active verbs and short, simple sentences, with one concept per sentence in short paragraphs.	100%			
7.	Materials avoided or defined difficult words and concept. Examples were used to clarify.	100%			
8.	Used terms consistently (e.g., "HIV" and "AIDS virus" were not used interchangeable).	100%			
9.	Materials were straightforward and clear. (Did not use abbreviations, acronyms, euphemisms, symbolism, statistics, or anything else that would cause confusion).	100%			
10.	Text used line drawings if illustrations were included.				100%
11.	Illustration of anatomy showed position of organs within the whole body (gave relative size and location reference).				100%
12.	Text used lists, bullets, or illustrations instead of long discussions. Visuals (overheads, slides) were used to emphasize key points.	100%			
13.	Text was underlined, boldfaced, or "boxed" fro reinforcement.	100%			
14.	The text dispelled myths; used acceptable channels, refers to value systems for reasons to change behavior or adopt a new perspective.	100%			
15.	Materials provided a call for action.	100%			
16.	The text illustrated manual skills from audience perspective.	100%			
17.	The text provided reasons for changing behavior.	100%			

TABLE X – Continued

Material Review Checklist	Excellent	Fully Successful	Needs Attention	Not Applicable
18. Materials provided current and accurate medical information.	100%			
19. Materials did not contain sexual preference or racial, gender, or ethnic bias.				100%
20. Text offered alternative behaviors to the one(s) that put a person at risk.	100%			
21. Realistic and relevant examples were given.	100%			
22. The format of the text was not visually distracting.	100%			
23. Graphics were immediately identifiable, relevant, and simple. They reinforced text.	100%			
24. Effectiveness of multicultural emphasis.				100%
25. Appropriateness of multicultural activities.				100%
26. Appropriateness of multicultural content.	100%			
27. Appropriateness of multicultural objectives.	100%			

Source: CDC, June 1990).

language that was difficult to understand. The participants also indicated that the program provided highlights to reinforce the text.

All of the participants indicated that the course should receive a score of excellent for its efforts in dispelling myths and explaining reasons for changing behaviors and gave ideas for alternative behaviors to reduce one's risks. It was also noted that the materials provided accurate medical information. The participants believed the course provided realistic and relevant examples.

The participants also determined the course materials were easy to read. They unanimously agreed that the font was appropriate. The sentences were neither too short

or too long. They also gave a score of excellent regarding the reproducible handouts/drawings that were available in the training manual.

Finally, the multicultural implications received scores of excellent as it related to the multicultural emphasis. The participants indicated that the multicultural activities were excellent. Each of the participants found the multicultural objectives and the multicultural content to be excellent.

Only a few of the participants answered the open-ended questions at the end of the questionnaire. Most of the respondents indicated they enjoyed the trainer. One of the respondents indicated, "the trainer was great! I liked him a lot!" A second respondent said, "the trainer was the bomb!" The third respondent said, "the teacher was good."

The following information provides the reader the opportunity to view the respondents' answers by percentages of each item on the questionnaire at a glance.

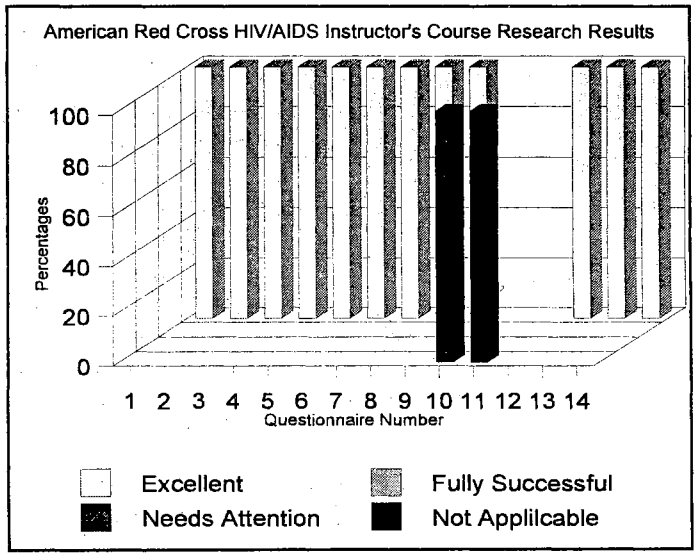

Figure 1. Responses to Questions 1 through 14.

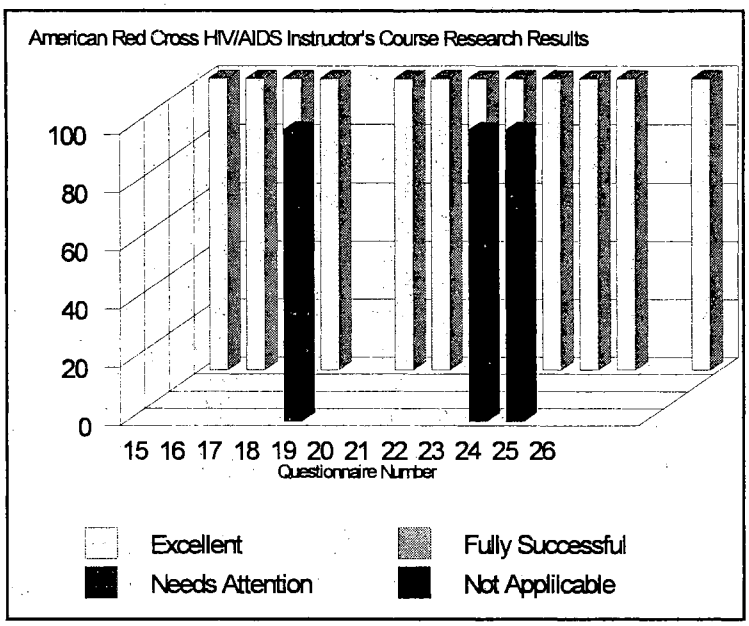

Figure 2. Responses to Questions 15 through 27.

Sample Participants for Focus Group Number One

The participants in focus group number one were part of the original survey respondents. The focus group members were randomly selected and contacted by phone to participate, four of the six participants met to discuss the research questions. After the focus group started, a rapport building exercise was conducted to allow the participants and the researcher to become more familiar with one another.

In this section each participant will be introduced prior to sharing the information shared during the focus group. Following the introduction of each participant, the researcher will give an observational remark about each participant.

Each participant was asked to identified themselves by the names they wished to be identified as in this study and tell the members of the group one adjective that started

with the first letter of their names they would use to describe themselves. They also told what type of work they did for a living. They were provided with a list of age ranges to identify the age range they were most likely with which to be affiliated.

The researcher provided the participants with an example of how this exercise works by herself as "Magnificent Marsha!" She described herself as a Professor at a Private Methodist University. Lastly, Marsha indicated she was in the 31-40 group. The researcher then asked if they understood how the exercise worked. The group indicated they understood by nodding their heads and verbally responding "yes."

Participant Number One: Pam

The first participant introduced herself as "Passionate Pam." She said,

> I'm twenty-eight years old. I don't have no kids, no husband and no problems. I go to church regularly and I'm involved with the kids at my church. I thought it would be a good idea to get trained in the Red Cross' program so I could talk to the kids at my church.

Researcher's Observations – Pam appeared very comfortable speaking during the introductions. She has a lot of personality. She did not have on any make-up and her hair was immaculate. It was in a French roll that looked like she had just left the beauty parlor. She had on a jean dress with embroidered flowers on the front.

Participant Number Two: Daisy

She introduced herself as "Dazzling Daisy." She explained,

> I work for a local government agency and I wanted to take the course so that I could do training sessions at my agency for the minorities because my boss thought it would be a good idea. I'm older than fifty and too young to be dead.

The other members of the group chuckled and then the next participant was introduced.

Researcher's Observations – Daisy was paying close attention to what was going on during the Pam's introduction. She was leaning forward during Pam's introduction. It was as if she was making sure Pam included everything she was asked to include and was anxious to introduce herself as "Dazzling Daisy." She wore glasses and very casual slacks and a buttoned down blouse. Her hair was short and dyed red. After her introduction, it was obvious that she had a great deal of personality and was anxious to get started.

Participant Number Three: Melvin

He introduced himself as "Marvelous Melvin." He told the group members that he worked at a non-profit organization and work with at-risk youth and adults for drug abuse.

> I have done this for several years. I try to get people to understand that using alcohol and other drugs can put them at greater risk for getting diseases such as cancer heart disease, sexually transmitted diseases and AIDS. Sometimes, they don't seem to get it. But, I keep trying to get them to understand Black folks are killing themselves and they don't have to do that.

Melvin said, "I think I liked it better when I was in Passionate Pam's age group. Now I'm in the 'one-foot-in-the-grave-and-one-foot-on-the-banana-peel-group.'" Daisy cut in and asked him, "Dang, how old are you? Now, you don't look as old as me." Melvin said, "No, ma'am. I'm in my early forties." Daisy said, "Child, you ain't seen nothing yet. You just wait. When you get as old as I am then you can say something about being old."

Researcher's Observations – Melvin was a nice looking young man who wore glasses. He was dressed casually. He had on Tommy Hilfiger jeans, a Tommy Hilfiger oxford shirt and Cole*Haan shoes. He acted as if he was a little bit mischievous and looking to stand out in the group. His hair was cut into a fade and was obviously recently done. He was well manicured from head to toe.

Participant Number Four: Carmen

She introduced herself as "Caring Carmen." She said,

> I am a Health Educator and have been for about fourteen years. I supervise other health educators in Oklahoma County. I recently took this course to brush up on my skills as an educator of health and prevention programs. Some of my subordinates have already taken the course. The others will be taking it soon. I am in the forty to fifty-year-old range.

Researcher's Observations – Carmen had on designer clothes, carried a designer hand bag and had designer sunglasses resting on her forehead. Her nails were manicured. Her hair was long and black. She sat with her legs crossed at the ankle, leaning back in her chair with her arms folded. She seemed very reserved and acted somewhat condescending.

Research Questions

The reacher was astounded that none of the participants returned the research questions answered. In fact, all of the participants that responded within the allotted time only returned the questionnaire.

After consulting with the panel experts, the decision was made to have the members of the focus group answer the research questions to obtain the data proposed in Chapter III. The results of the research questions will be discussed later in this section.

The participants were asked to revisit the "Health Education and Risk Reduction Activities Quality Assurance Questionnaire" to see if the participants had anything they wanted to address that was not previously addressed. None of the participants wished to add or change anything they initially submitted.

To facilitate understanding of the responses of the participants during the focus group, the researcher will provide the reader with the question posed to the members of the focus group and follow each of the questions with the responses from each of the participants in the following order: Pam; Daisy; Melvin; and Carmen. The following research questions have been identified as a foundation for this study and were asked of the participants in the focus group.

Question Number One

Should Professional Health Educators That Are Currently Certified American Red Cross HIV/AIDS Instructors Be Required to Participate in the American Red Cross African American HIV/AIDS Instructor Course to Teach African Americans? Why or Why Not?

Overall, the participants admitted to the researcher they had never thought of this before. However, they explained it was a good idea to learn more about African Americans and how HIV and AIDS has affected the African American community, they

thought it was not necessary for them to take the course to learn how to talk to African Americans since they were African Americans. They explained that the course probably would have been more beneficial for the trainers that were from other racial groups so that they could learn about African Americans and their response to the AIDS epidemic.

Pam explained,

> I never thought of it before, but it seems kind of silly for somebody that is Black to have to learn how to talk to somebody that is Black. For me, I'm glad I took the course though because I learned stuff that I wouldn't have ordinarily. That was pretty neat. I really liked the sessions where we learned how to talk to kids. Do y'all remember when we gave presentations to those bad kids? That was hard. But, it made me think about what kids could ask me when I make a presentation.

Daisy said,

> When I was young, all we had was our own stuff. It probably should be required for somebody that ain't Black. But, to make somebody that is Black take it to teach African Americans, *if* they are already certified by the Red Cross to teach AIDS take it seems silly. But I agree with Pam, it had some training exercises in it that we didn't have in the regular training course that I thought was good.

Melvin said,

> Why do N.....s have to take more train'n than everybody else to train our own folks. That don't make no sense. They need some White folks taking that course. Black folks being in that class is like preaching to the choir and ya'll know it. The class was cool and all but it is kinda wrong to have N.....s do extra and leave the other folks alone. So what does that mean? Do the White folks never talk to N.....s? What really goin' on?

Daisy said, "Melvin, you ought to be shame of yourself. Your Momma would not want to hear you calling Black folks N.....s. Would she? Melvin said, " no ma'am. But

you know I'm telling the truth." Daisy explained, "some truth may exist to what you are saying but this is supposed to be a research project of this girl and you show'n out."

Melvin said, "I'm not showing out. I'm being real. That is what is wrong with some of the older generation: You guys were so busy being oppressed that it scares you when someone young speaks the truth." Daisy said, "You can tell the truth without showing your color." Melvin said, "Ain't nothing wrong with my color or how I express myself. Now I respect you because you are my elder. You should respect me for being true to myself." Daisy said, "Fair enough. I'm watching you." Melvin said, "Cool. Don't get too close and look too hard. If you do, I might have to report you." The group exploded with nervous laughter and moved to the next participants response.

Carmen said,

> I have never thought about the fact that African Americans took extra training and paid more money that the European Americans. However, I am glad that I participated in the separate training session. It helped me to focus on the needs of African Americans as it relates to HIV and AIDS. I do health education but, I was fortunate to learn information that was not covered in the other training sessions. If you think about it, people can learn more about certain cultures, if they wish. We were not forced to learn how to train Jews, for instance, a group that we might not ever have to train. So, why should other people be forced to participate in training sessions for specific population they might not ever have the privilege of presenting to. Being *required* to take it when you are already from that specific minority group is a trip though. But it was a good trip.

Question Number Two

What Are the Perceptions of the Graduates of the American Red Cross African American HIV/AIDS Instructor's Course Regarding the Strengths and Weaknesses of Multicultural Emphasis?

The focus group decided if would be better to make a list of strengths and weaknesses on a piece of paper so they could keep track of what they said, in an effort to answer the question. As a result, Pam, Daisy, Melvin and Carmen compiled the following list as shown in Table XI.

TABLE XI

FOCUS GROUP RESPONSE TO QUESTION TWO

Strengths of the American Red Cross African American HIV/AIDS Program	Weaknesses of the American Red Cross African American HIV/AIDS Program
Clearly defined objectives	Multimedia used during training is dated which included videos and posters
Clearly defined target population	Follow-up is not encouraged
Based on epidemiological profiles	Does not currently advertise to spread the prevention message
Utilizes common language	Program is too long
Practice skills are provided for future instructors by conducting mock teaching sessions	Does not address other ethnic minority populations during the training sessions such as Hispanic or Asian populations
Utilizes cultural relevancy/appropriateness to reach and empower the target population	Rigid in programmatic structure/content
Program is tailored to the needs of the African American community	Focused on short-term or one-shot HIV/AIDS education programming
Encourages future instructors to plan programs in sites that are accessible to the audiences	
Encourages future instructors to link individuals from the audience to testing sites	
Provide future instructors with a variety of teaching outlines to accommodate 30 minutes through sessions that can last for a few days	
Have multiple programs for the African American audience which includes a teen emphasis and an adult emphasis with African proverbs as the guide for the lectures	
Provides contexts for practicing skills	

TABLE XI – Continued

Strengths of the American Red Cross African American HIV/AIDS Program	Weaknesses of the American Red Cross African American HIV/AIDS Program
Addresses communication styles of African Americans	
Future instructors are encouraged to address their own personal opinions and biases regarding HIV/AIDS	
Hands-on learning opportunities are provided	
Cultural and social context are appropriate	
Group support is encouraged among future instructors	
Program addresses spiritual/religious beliefs	

Question Number Three

What Are the Perceptions of the Graduates of the American Red Cross African American HIV/AIDS Instructor's Course Regarding the Appropriateness of Multicultural Content and Activities and Objectives?

The members of the focus group unanimously agreed that the multicultural content in the American Red Cross African American HIV/AIDS Instructor's course was excellent! They especially enjoyed the mock training sessions to give them the opportunity to practice teaching to various types of ethnic groups such as urban youth, religious groups, homosexuals, homophobic groups and to conservative older African Americans. The focus group further explained they like how the objective were clearly identified by the trainer prior to beginning each session. They believed this helped them to focus on what they needed to know to facilitate successfully completing the program.

Pam responded to this question by saying,

> As a graduate of this course, I think that the multicultural emphasis was excellent. Everything that I wanted to know was addressed in this course. It allowed me to expand my thinking about some things. Even though I'm Black, it was neat to look and learn from this curriculum that was developed for African Americans.

Daisy explained,

> I thought the multicultural content and activities and objectives were excellent! I thought the material was pretty well put together. It was "right on time."

Melvin said,

> Shoot, I thought the course was the bomb! I still think everybody should have to take it. The way the objectives was explained and how the material was presented and what we learned was really good. The Red Cross' people did a good job in how they laid out the program. It had a lot of practicing for us which was good because all of us don't get to make presentations to the same kind of Black people. For instance, Daisy probably won't get to make presentations to at risk youths and Pam won't get to make presentations to homosexuals or kids that are drug exposed. The course prepared them to make presentations to different kinds of Black folks. Anyway, I thought it was great the way they "hooked it up!"

Carmen said, "I concur with everyone else. I thought the program was most appropriate. It provided multidemensions for training opportunities for the participants. The multicultural content and activities were well prepared and addressed very well during the training program."

Question Number Four

What Are the Perceptions of the Graduates of the American Red Cross African American HIV/AIDS Instructor's Course Regarding the Need for this Course to Be Required for All Certified ARC HIV/AIDS Instructors?

Only three of the four members of the focus group were willing to answer this question. They believed it was a good idea to promote the course more so that more White people would consider taking the course. They explained they had mixed feelings about the existence of the course. They explained they liked having "their own class." But, at the same time, they felt like, "why do we have our own class?" They explained they didn't know if this meant they were going forward in society or stepping back. The demonstrated mixed emotions about the issue and suggested that the group "move on."

Melvin responded of sequence to answer this question. He said,

> I told ya'll before it is a trip that no White folks had to take this course. They the main ones that need to hear how to deal with N.....s. They forevermore try'n to talk to Black folks and ain't gotta clue what a brother or a sista is going through, where they came from and where they going. The course is good and White folks should have to take it too just in case they run up in a presentation and some N.....s are there. So they don't freak out if a brother asked them something about their business. Y'all better recognize, White folks need to know what's up.

Members of the focus group seemed uncomfortable about how excited Melvin responded to the question and suggested that the group move on.

Pam said, "Let's move on before Melvin starts showing out."

Soon after, Daisy said, "Lord, have mercy Jesus. This child is something else." Carmen held her head down and shook her head from side to side. The researcher

determined emotions were running a little high and agreed to move onto the next question, as the group had requested. The researcher was concerned that someone might leave if Melvin continued to show intense emotions and continue to use the "N" word.

Question Number Five

What Are the Perceptions of the Graduates of the American Red Cross African American HIV/AIDS Instructor's Course Regarding Recommendations for Improving the Multicultural Dimensions of the Course?

The members of the focus group agreed there is nothing they would do to improve the multicultural dimensions of the course.

Pam said, "I wouldn't change nothing."

Daisy said, "me too."

Melvin said, "I don't have anything else to add."

Carmen said, "I think we're done here.

After completion of the focus group, the researcher indicated that the members of the focus group would receive a copy of the abstract and the results of the study if they would like to have a copy. They indicated they appreciated the opportunity to participate and hoped that they did not mess up the researcher's project by "showing out."

The researcher thanked the participants for spending their afternoon answering research questions. The researcher also indicated that if further information was needed, they would be contacted.

After an initial review of the data collected from the first focus group, it was determined that several questions went unanswered and should be addressed for the purpose of fully developing this study. Opportunities to further expound on issues overlooked in this first focus group will be addressed in the next section of focus group meeting number two.

Focus Group Session Number Two

Each of the participants was contacted by phone and asked to participate in a second session of the focus group to find out more information on information that was partially dealt with during the first session. The researcher explained it was crucial for every member from the focus group to attend to ensure that the dynamics of the group would not be drastically changed. The researcher knew that this could drastically impact the data gathered if one of the participants was abscent. A date and time were established to meet and the second session was conducted. As before, during session number one of the focus group, the information will be disseminated by posing the research question and asking each person to respond and record the information in the same order, for each question.

The following questions were posed to the participants of the focus groups.

Question Number One

Each of the Participants That Mailed Responses Back to the Researcher Had the Same Responses. Why Do You Suppose this Occurred?

Prior to answering this question, the researcher gave each of the participants a copy of the questionnaire.

Daisy indicated she filled out the questionnaire honestly and accurately,

> I marked the answers that I thought were the most appropriate. I did not call anybody to ask them what they marked. I didn't even know who else got a survey. I don't know why anybody would answer the questions with something they did not believe. I would not change any of my answers.

Carmen quickly responded that her answers were accurately marked for each corresponding item. Carmen continued to say, "I suppose we all thought the same thing. I think the curriculum is good. There are a few things that could be changed and we talked about those things in our first session. By and large, I think it is a good course."

Melvin replied,

> You know I marked what I thought was right! Everybody that answered the thing must have had the same feelings about the course. I wouldn't change any of my answers. I think I was honest with the questions that were asked on the survey.

Pam explained her survey was answered quickly and after looking at it a second time, she was sure that she answered her survey appropriately. Pam said, "I would not change a thing. I guess we think alike. And, the trainer was the bomb!"

Question Number Two

The Focus Group Identified Several Weaknesses Evident in the American Red Cross African American HIV/AIDS Instructor's Training Course. But When Asked If the Focus Group Could Identify Recommendations for Improving the Multicultural Dimensions of the Course: The Group Indicated You Would Not Make Any Changes. Why?

Daisy replied,

> I thought we answered that by making the list of weaknesses. I didn't know we were supposed to say something else. I saw it as the same question. I thought you asked again like some people do to see if you are going to say the same thing twice.

Carmen indicated she agreed with Daisy. Carmen said, "I thought we covered that information in another question and I didn't have anything else to say. So, I said, 'I had nothing to add.'"

Melvin said, "You 'research types' are always looking for some secret. I agree with everyone else. There was nothing else to say."

Pam explained, "I agree. Did we do something to mess you up?"
The researcher explained that the participants did not "mess up" anything. The researcher indicated that there were some missed opportunities to get more information about the training course and that was the reason for conducting a second session.

Question Number Three

None of the Participants That Participated in this Research Returned Answers to the Research Questions. As a Participant in this Study Why Do You Suppose this Occurred?

Daisy said,

> I didn't do it because I thought it would take too long to write out all of that stuff. And what difference would it make if I didn't send it anyway. I'm just one person anyway. I knew that some of the other people would send in their information to help you get what you needed. Anyway, I don't have a computer at home and I could not work on the thing at work. Now could I? I'm sorry if me not sending my information in messed you up. But, well, anyway, I'm here now to help. This was easier than writing my answers down on a sheet of paper.

Carmen indicated that she thought it was too many questions to sit down and respond answer. Carmen stated, "I could have done it if I had not gone out of town for a few days. I tried to send in my survey by the deadline and just left out the other information. I thought that was better than nothing."

Melvin said,

> Huh. I didn't have the patience to sit and articulate answers that I thought you might want to see. Plus, I didn't want nobody looking at my stuff and laughing at the way I spelled something or what I was trying to say. It is easier to just talk than to sit and figure out what and how you are supposed to say something. And, I didn't want it coming back on me. I know that the information you sent had codes on it so you could track down what we said.

The researcher explained that the information was to be kept confidential and the information they received was not coded to decrease the incidence of the participants not

responding because of fear of being identified. The researcher further explained that precautions have been taken to ensure the confidentiality of each participant in the study. Lastly, the researcher explained that each of the participant's identity would be kept in the strictest of confidence so they would not have to worry about anything that they had discussed. Melvin's short lived anxiety subsided and the next respondent quickly answered.

Pam said,

> I didn't want anybody to think what I thought was stupid. I know folks sit around and laugh at what they get back because something is spelled wrong or the proper grammar was not used. I decided not to go that route. I hope me being here today will help make up for that.

Upon completing her answer, Pam had a brain storm. She said, "Let's write down why people might not have responded." The rest of the focus group members agreed.

The following list is a list of potential reasons why the other respondents did not answer the research questions included with their questionnaires:

- Questions were too hard;
- The participant's felt their answers would be dumb and someone was going to laugh at them;
- They did not have enough time;
- They did not realize how much their answers meant to the researcher's project;
- They were out of town because of the holidays and being on vacation;
- They did not have equipment available to prepare answers; and/or

- They did not want to submit handwritten materials because it may be perceived as unprofessional.

Question Number Four

What Specific Types of Things Can Be Done to Correct the Weaknesses Identified in the First Session?

Prior to answering this question, the participants were given a list of the weaknesses they identified in the previous session. The researcher indicated that it was important to identify specific things to do to improve the course. For the purpose of organizing the material in a manner that is easy to understand, the researcher will provide a table with the weaknesses identified and a section for the participant to respond to each item. The participants were also asked to respond to *each* item regardless if it was not a weakness they had identified in the first focus group. The researcher asked if they had any questions. They indicated they had no further questions and the focus group proceeded.

Daisy said, "I will just go down the list and answer what I think could be done. Here we go." (See Table XII).

TABLE XII

DAISY'S RESPONSES TO IDENTIFIED WEAKNESSES

Weaknesses of the American Red Cross African American HIV/AIDS Instructor's Course	Ways to improve the identified weakness - *Participant's response to each item*
Multimedia used during training is dated which includes videos and posters	"They need to make a new video. The information in the video was good. But it was so eighties. A lot of the posters they used were of folks that used to be the bomb. Like, Patti Labelle. Don't get me wrong I like her but I think people would like to see some body who is currently popular like Toni Braxton or whats that nasty girls name? Oh yeah, Li'l Kim. I think people might like that more."
Follow-up is not encouraged	"I ain't particular about following up myself. But if I was, I would take a sign in sheet and get them to write their phone numbers down and their addresses so I could get in contact with them."
Does not currently advertise to spread the prevention message	"I think they need to have more information on the radio and in our news papers about prevention so that people will realize this disease is still killing our people and we should not forget that and become careless. But today, you don't see as much stuff as you used to. It is like after Magic got infected there was a lot going on. But know you don't hear nothing. We need to do something about that."
Program is too long	"Lord have mercy Jesus. I thought I was going to die. They need to figure out how to shorten the program and still cover all of the information. There were some breaks I would rather have skipped to finish before three days. Whew!"
Does not address other ethnic minority populations during the training sessions such as Hispanic or Asian populations	"I don't think it necessarily has to cover any other group. After all, it was for us."
Ridged in programmatic structure/content	"The program is very rigid. But it is kinda 'ok' with me because you don't have to think about what comes next. It is all laid out for you."
Focused on short-term or one-shot HIV/AIDS education programming	"All I am interested in is doing my 'one-time' sessions to get the job done. The rest is up to them."

Carmen said, "OK, I will try to make this quick and painless. I will try not to take up all of your time. Not that you did Daisy. I want to do as well as you did." (See Table XIII).

TABLE XIII

CARMEN'S RESPONSE TO IDENTIFIED WEAKNESSES

Weaknesses of the American Red Cross African American HIV/AIDS Instructor's Course	Ways to improve the identified weakness - *Participant's response to each item*
Multimedia used during training is dated which includes videos and posters	"First of all, I agree with Daisy. The video was out of line. I mean goodness gracious. The people in the movie had gerry curls. How long ago was that? They out to be ashamed of themselves. They know darned good and well they have enough money to update that video. The content was good. But the age of the video took away from that. It was distracting to me. I also agree that the posters should include more current stars that are not infected. How is Magic going to be talking to somebody all infected? That is so wrong. They need somebody that is a role model. If it has to be a sports person, then, use somebody like Grant Hill. Or, they could use somebody like Halle Berry or Janet Jackson. That is it for that one."
Follow-up is not encouraged	"I personally would like to know if they listen to what I had to say by finding out years down the road if they were still using the information I had shared with them. I would like to get the names and contact information for the people that attended my sessions."
Does not currently advertise to spread the prevention message	"I know we have two African American papers in the 'community' and there is no reason why they could not advertise HIV/AIDS prevention messages. We also have three African American radio stations that could run PSAs to get the word out to our people."
Program is too long	"I would also like to see the program shortened into maybe two days and have the people in the class read some of the material on their own."
Does not address other ethnic minority populations during the training sessions such as Hispanic or Asian populations	"I am the person that gave this response. But, the course is long enough. What they could do is use the three days and cover less about the African Americans and include another group we are likely to encounter such as the Hispanic population. I know they have a separate course for that but I don't want to take it too and pay more money to learn about their culture. They should put us together. Maybe that is stupid because we take up three days and there is not much telling how many days they cover. We might not ever get through training. Never mind. They should shorten the course."
Ridged in programmatic structure/content	"I like the format. It does not allow for a lot of freedom. But, it is inclusive of all of the necessary information. It has all of the fat trimmed off."
Focused on short-term or one-shot HIV/AIDS education programming	"I would like to access some of the people trained in the sessions after it was all over, down the road. Some of our people need more than a one-time session. They need on-going comprehensive health education."

Melvin said, "it is about time. You ladies took up all of my time. I'm just kidding Miss Lady Ma'am." (See Table XIV).

TABLE XIV

MELVIN'S RESPONSES TO IDENTIFIED WEAKNESSES

Weaknesses of the American Red Cross African American HIV/AIDS Instructor's Course	Ways to improve the identified weakness - *Participants response to each item*
Multimedia used during training is dated which includes videos and posters	"I agree with the other two ladies. So, I'm not going to waste time with this one."
Follow-up is not encouraged	"I would like to know how the people are doing long after I'm gone. Sometimes, I wonder if they listened and if they were using safer sex practices 'cause I know they ain't keeping it to themselves. I would like to have their numbers or addresses so I could send out a little survey in about a year to see whats up."
Does not currently advertise to spread the prevention message	"Ditto to what Carmen said."
Program is too long	"I know they could cut that program down to two days. We could have looked at some of the readings on our own."
Does not address other ethnic minority populations during the training sessions such as Hispanic or Asian populations	"It was for Black folks and that was just fine with me. I ain't trying to make the program longer by adding somebody else to the equation."
Ridged in programmatic structure/content	"Sometimes I would like to include other stuff that is not in the content. Actually, most of the time I do. I'm just trying to keep it real."
Focused on short-term or one-shot HIV/AIDS education programming	"I kinda already spoke on this. Next. Oh, I'm done. Next victim please."

Pam said, "Let me say this about what has already been said. What I have to say has already been said." (See Table XV).

TABLE XV

PAM'S RESPONSES TO IDENTIFIED WEAKNESSES

Weaknesses of the American Red Cross African American HIV/AIDS Instructor's Course	Ways to improve the identified weakness - *Participants response to each item*
Multimedia used during training is dated which includes videos and posters	"Ditto. I agree with what Daisy, Carmen and Melvin said."
Follow-up is not encourage	"Ditto. I agree with what Carmen and Melvin said."
Does not currently advertise to spread the prevention message	"Ditto. I agree with what Daisy, Carmen and Melvin said."
Program is too long	"Ditto. I agree with what Melvin said."
Does not address other ethnic minority populations during the training sessions such as Hispanic or Asian populations	"Ditto. I agree with what Melvin said."
Ridged in programmatic structure/content	"Ditto. I agree with what Melvin said."
Focused on short-term or one-shot HIV/AIDS education programming	"Ditto. I agree with what Melvin said. OK, I'm nervous. I agreed with Melvin way too much. Whats really going on? Just kidding Melvin."

Upon the completion of the second session of focus group number one in a series of the focus groups, the researcher thanked the participants for taking time out of their busy schedules for participating and promised to provide them with a copy of an abstract of the study of they would like. They thanked the researcher for having them to participate. They hugged the researcher and each other: Session two was complete.

Focus Group Session Number Three

After the second focus group was conducted, a third focus group session was held to address a crucial issue that was brought out in the first session in the series of focus

groups. A comment was made regarding "Why do African Americans have their own HIV/AIDS class?" As a result, focus group number three was asked to answer the following question: Do you perceive the development of this course as going forward or backwards? Why?

The researcher contacted six participants to participate in the third session of the series of focus groups utilized to answer the research questions posed for this study. Unfortunately, three of the six participants were able to meet to answer the research question posed. This question was posed after meeting with the first focus group and the researcher's Doctoral Committee members.

The third session began in the same manner as the first meeting of the first focus group. Each member was asked to introduce themselves and identify themselves by the name they wished to be identified. Additionally, they had to provide an adjective that started with the first letter of the name they selected. The researcher provided the same example as given during the first session of the first focus group. The researcher asked if there were any questions and the group indicated they did not have any questions.

Focus Group Number Three Participants

Participant Number One: Casey

Casey cleared her throat and said, "I'm 'Caring Casey.' I work at a non profit organization doing community service type work and some health education programs with kids that are b.a.d. And, I'm in my twenties."

Participant Number Two: Alexis

Alexis began by saying,

> Hello, everyone, I'm "Amazing Alexis." I'm so bad I can't stand myself sometimes. I work with at-risk youths. Whatever that means. Anybody breathing this day and age is at risk. Anyway. I work with the kids most people are afraid to work with. They are officially the juvenile delinquents of the City. I am proud to be in my thirties. I'm almost grown up and proud of it. It is your turn sir.

Participant Number Three: Michael

Michael by waving at everyone at the focus group meeting and told everyone his name.

> Hello ladies. I'm Michael. I work with youth groups and apprentice programs that help young African American men grow up to become strong role models in their churches, with their families and their communities. I talk to young men that are in middle schools, churches, youth groups and anywhere people invite me to come and help their young men. I also talk to kids who are in high school and college age young men. I'm single and I believe in God. And, I am still in the 30-40 age group. For a little while anyway. I'm ready to get to work. What do we do next?

The researcher indicated it was time to proceed to answering the research questions posed to their focus group.

Question Number One

> *Do You Perceive the Development of the African American HIV/AIDS Instructor's Course as Going Forward or Backwards? Why?*

Casey indicated,

This is hard to respond to. I didn't grow up struggling picking cotton, trying to run off plantations and fighting for civil rights. All I know is how I grew up. I grew up in an area where there are White and Black families living in the same neighborhoods. My Mom and Dad always told me it was better to integrate than to separate. I have always tried to do that. But, on the same token, I know that everybody else has not had that same experience. That is why I took the course in the first place. I wanted to learn as much as possible about the African American heritage and how it relates to HIV/AIDS prevention so that I could be a better teacher when I do presentations for African Americans. I want to go into a presentation armed with as much information as possible. I wanted to be able to say I'm certified. So, I know what I'm talking about Even though I didn't live the struggle.

Casey further explained,

I think it was smart of the Red Cross to establish a program for African American people. We often feel like there is nothing that is ours. This program give the participants a since of belongingness. Well, it does me. I'll bet there are all kinds of people that complained in the first place and said, "how come you don't have nothing for African Americans?" And, I'll bet you those same people have complained about they keeping us separate but equal. I know how it goes. You just can't please Black people. It is a damned if you do and damned if you don't situation. I know you guys know what I'm talking about. While this program is progressive. I think we, as a people, are still going backwards.

Alexis replied,

I agree with "young blood" here on this. I think our culture is confused and tripping. We fuss and cuss about not having our own stuff. The "Man" gives us our own stuff. Then, we don't support our own stuff. We should have had a lot more people at that training session. We don't take advantage of what the majority tries to give us. Shoot, I think we are going backwards at warp speed. I say that because even though the program is progressive, we, as a people, don't take advantage, thus going backwards.

Michael explained,

> You ladies are right. Don't tell the brothers I said that. I think we are going backwards too, overall. We have a program that could help our people but we don't access the training like we could. The killing part is when you have a session and only five or six people come. Then they get infected and act like nobody will help them and the White man is trying to kill us.

After the participants answered this question, the researcher recalled that none of the participants submitted a response to the research questions that were enclosed with the copy of their survey question and decided to inquire as to why they failed to respond. The researcher asked them in the same order as the last question.

Casey quickly responded by saying,

> It looked too hard. I felt like there was nothing I could say that would help. I felt like I should be a doctor or a lawyer or something to answer that question. Then, I thought, it must have been a mistake that it was in my envelope and that only certain people was suppose to get it.

Alexis stated,

> I didn't think my answer would be missed. I knew it would take a long time to write my answer and decided it was better to send in part of the stuff you asked for rather than nothing. So, that's what I did. I'm sorry if I caused you any problems.

Michael, said, "Same for me. I'm sorry. I hope I didn't mess you up."

After hearing their answers the researcher asked them if they had a few more minutes to review the answers to the research questions which addressed the strengths and weaknesses of the American Red Cross African American HIV/AIDS Instructor's Course which was developed by focus group number one to see if the agreed, disagreed

or had anything to add. They all agreed to participate in extending their session of the focus group to address this issue.

Each participant was given a copy of focus group number one's responses to the question which identified the strength and weaknesses of the instructor's course. They were given several minutes to review the material. After they all read the material. The researcher reviewed the questions and the responses and asked each one what were their feelings.

Casey answered first. She said, "I don't see anything that I would take out or add. I agree with all of the strengths and weaknesses listed here. I'm sorry if you were looking for something else. I don't have anything else."

Second, Alexis stated, I think they made up a pretty good list. I can't think of anything else to add. I agree with what they said."

Third, Michael answered by saying, "the only think I would say is . . . I'll bet they were tired by the time they were set free. It looks like they came up with a lot of stuff. I agree with the ladies. They did a good job. I agree with their focus group."

The researcher asked if they had any other questions or concerns upon completing the focus group. Two of the participants indicated no by shaking theirs heads and one said, "no" out loud. The session of the third focus group concluded.

At the conclusion of the focus group, all of the members hugged each other. The researcher thanked them for serving such a vital role in this research project and promised to provide them with a copy of the abstract, if they would like to have a copy. After

several minutes of exchanging personal chatter, the group disbanded and the researcher immediately began to prepare the report of the meeting.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Preventing the spread of sexually transmitted diseases requires that persons at risk for transmitting or acquiring infections change their behaviors. The essential first step is for the health-care provider to include questions regarding the patient's sexual history as part of the clinical interview. When risk factors have been identified, the provider has an opportunity to deliver prevention messages.

Counseling skills, respect, compassion, and nonjudgmental attitudes are essential to the effective delivery of prevention messages. Using techniques that can be effective in facilitating a rapport with individuals can include using open-ended questions, using understandable language, and reassuring the patient that treatment will be provided regardless of considerations such as ability to pay, citizenship or immigration status, language spoken, or lifestyle.

Simply recognizing ethnic and cultural diversity is not enough. Understanding and respecting diverse values, traditions, and behaviors are essential if we are to actualize fully our nation's democratic ideals. The call for understanding and respect is based on a belief that the existence and expressions of differences can improve the quality of life for individuals, for ethnic and cultural groups, and for society as a whole. For individuals, group identity can provide a foundation for self-definition. Ethnic and cultural group

membership can provide a sense of belonging, of shared traditions and of interdependence. Members of minority groups have had restricted access to institutions in the larger society. This can change when society's views of ethnic and cultural differences are treated with respect and when individuals can define themselves ethnically without conflict or shame.

The Purpose of the Study

The purpose of this study was to investigate and obtain perceptions of the value of the American Red Cross African American HIV/AIDS Instructor's course from the trainer and the participants of the course. Within this study, insight into the strengths and weaknesses of the American Red Cross African American HIV/AIDS Instructor's course was emphasized. Additionally, suggestions to improve the course were developed for future use.

Research Questions

The following research questions have been identified as a foundation for this study:

1. Should professional health educators that were already certified American Red Cross HIV/AIDS Instructors be required to participate in the American Red Cross African American HIV/AIDS Instructor course to teach African Americans? Why or why not?

2. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the strengths and weaknesses of multicultural emphasis?
3. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the appropriateness of multicultural content and activities and objectives?
4. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding the need for this course to have been required for all certified ARC HIV/AIDS instructors?
5. What were the perceptions of the graduates of the American Red Cross African American HIV/AIDS Instructor's course regarding recommendations for improving the multicultural dimensions of the course?

Conclusions

This research project has answered the questions posed at the beginning of this study. There are several conclusions that can be drawn from the results of this study. These are:

- The course is perceived to be highly valuable and helpful by the participants of the study;
- The instructional materials are perceived to be effective and appropriate by the participants of the study;

- The course is perceived to be very demanding in terms of time spent in the course;
- The instructional practices utilized in the course are perceived to be appropriate and beneficial by the participants of the study; and
- The course was perceived to be of high quality by the participants of the study.

Recommendations for Practice

There are several recommendations for future practice that have been developed as a result of the conclusions of this study. Those recommendations include:

- The course should be provided to all trainers regardless of the trainer's ethnicity;
- The course should be updated with regard to the instructional visual aids and posters that reflect more modern dress and role models;
- Efforts should be made to shorten the course from three to two days while keeping the current content;
- The course content should be divided into separate sections focusing on adolescent and adult training strategies;
- The course should be required of African Americans since it provides insight for African Americans with different life experiences than those of the target population;
- Follow-up strategies should be included to allow trainers the opportunity to gauge the results of their efforts with their trainees;

- Mock presentations should be conducted to gender-specific audiences as well as class-specific audiences to determine if this could influence the effectiveness of the American Red Cross African American HIV/AIDS Instructor's Course;
- Efforts to advertise the course should be more aggressively made in local mass media to improve participation; and
- The actual courses should be aimed at a younger age group to increase the likelihood of having risk behavior impact.

Recommendations for Future Research

These findings suggest that further research is necessary to see how culturally specific HIV/AIDS Education Instructor's Course might be affected by the setting of the instructor's course. It is important to note that this is the researcher's first evaluation of the American Red Cross African American HIV/AIDS Instructor's Course. This information might be best used as a basis for further study. Additional evaluation studies are needed to build on the findings of this study. As a result of conducting this study, the following points have been identified as a foundation for further research:

- Research focusing on the impact of the strategies taught in the African American course on community participants should be conducted.
- Longitudinal research should be conducted to measure the impact of the African American course on trainers' ability to effectively reach the African American community;

- Survey research of this type with similar populations which include open-ended questions should be written in short statements, use simple language, and only require short answers to facilitate written responses; and,
- Research should be conducted to identify the factors that contribute to low levels of community participation in these types of courses.

Obviously, research such as this is not intended to draw conclusions about the response of all African Americans of this program. Audiences will differ in their response to the program depending on whether they are reach in a church, classroom, public health clinic or a community center. Only when these differences are understood, and taken into account, will the American Red Cross African American HIV/AIDS Education Program and other programs that are similar in nature successfully reach their goal of providing African Americans with the knowledge and skills the need to protect themselves from HIV infection.

Observations

Upon completion of this study, several observations were made. Those observations, as related to the study, are:

- Even though inclusion of content relating to other cultures was seen as desirable by the study's participants, their inclusion for the course is not recommended since this would most likely lengthen the duration of the course, which is recommended to be shortened;

- Even though participants felt one weakness in the course was its "rigidity," the focus group participants felt this structure was needed and desirable to keep them on task and complete all the materials and reach each objective as efficiently as possible;
- African Americans are ambivalent about having a separate course;
- There was as much variance among the group's participants as there was a difference between the groups;
- The course was designed as if the curriculum was monolithic and, in fact, the group was multiethnic;
- The idea of "them" and "us" was prevalent among the participants.
- Even though a special course for African American trainers on African Americans was seen as somewhat foolish and controversial, the focus group participants did comment that the course was helpful and should be kept, especially since not all African Americans have had the same types of life experiences as those they are trying to serve; and
- The issue of whether this course implied that African Americans were actually "losing ground" in American society needs to be taken within the context of the African American community at-large. The participants of the second focus group were very clear about the fact that what troubled them was the lack of participation and involvement by the African American community in these types of programs. It should be noted that this phenomenon may be related to the increasing incidence of HIV/AIDS in the African American and other ethnic minority communities. Even

> though there may be effectively designed and delivered interventions to change risk behaviors, including cultural elements to increase the likelihood of effective communications, if the target populations does not participate, then the message was not received.

Although HIV/AIDS education programs have been around for many years, most HIV/AIDS education programs have not been nearly as effective as hoped. That is evident by the continuation of the spread of the disease among African Americans and other minority groups. While the infection rates of homosexuals have decreased, the rates of populations such as African American women have increased.

Since, HIV and AIDS is a major public health concern, HIV education must reach children before they develop patterns of high risk sexual behavior. Programs that have been developed to promote abstinence should continue to be promoted. Oftentimes times, programs are developed and not continued which sends a message that the problem no longer exists. Strong government, private, and joint support is needed for research and programs on prevention and treatment; for medical and social services for people with HIV/AIDS, their families, and for the continued development and delivery of clear, accurate, age-appropriate prevention information for all people.

The American Red Cross has spent many years responding to the health crisis of America. The American Red Cross continues to bring its humanitarianism to society by implementing programs to address the HIV/AIDS health epidemic. The American Red Cross has developed several HIV/AIDS prevention programs which include: HIV/AIDS Instructor Program, Hispanic HIV/AIDS Program, Workplace HIV/AIDS Program, and the African American HIV/AIDS Program. While the American Red Cross has

responded to the needs of some populations, there are still several groups that have the need for culturally specific HIV/AIDS Prevention programs.

It is clear that the American Red Cross African American HIV/AIDS Program falls into what can be labeled as the conflict theoretical paradigm. The program was initially conceived by the majority to help the minority population decrease their incidence of HIV/AIDS. It was clear they were not helping themselves regardless of it was due to lack of knowledge or power.

In an effort to arrive at a consensus, it was necessary to resolve the conflict. However, to date, this conflict is still prevalent in the African American community. It is evident by the continuation of rising HIV/AIDS rates among its community members and poor participation during presentations. There are no methodical prevention programs which exist to address the incidence of HIV/AIDS in the African American community. Therefore, the African American community has remained a splintered fragment of the majority population with rising HIV/AIDS infection rates.

The American Red Cross African American program is good. However, it is not being effectively utilized. This is a foundation for further research to develop mechanisms to effectively utilize a good program to help the African American community to create a consensus among its people.

Those that lack power are the least likely to change. Therefore, powerlessness leads to hopelessness. Thus, the infection rate among African Americans is likely to continue to increase.

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APPENDIXES

APPENDIX A

GUIDELINES FOR HEALTH EDUCATION AND RISK REDUCTION ACTIVITIES QUALITY ASSURANCE MATERIALS REVIEW CHECKLIST

Guidelines for Health Education and Risk Reduction Activities

QUALITY ASSURANCE

MATERIAL REVIEW CHECKLIST

TITLE: _____ AUTHOR: _____

REVIEWER: _____

DATE: _____

DIRECTIONS: Check the appropriate columns to indicate degree to which the author met criteria:

EXCELLENT indicates that performance met criteria beyond fully successful.

FULLY SUCCESSFUL indicates performance met criteria successfully.

NEEDS ATTN indicates performance needs supervisory guidance to meet criteria.

N/A indicates this criteria did not apply to this situation.

April 1995

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Check only within and not between the boxes. If undecided, use "comments" section to clarify.

1. Material is clearly introduced and states the purpose of the text to the reader.				
2. Major points of text are summarized at the end.				
3. Materials are brief, concise, and in the language or dialect of the target audience.				
4. Materials are written at the educational and reading level of the target audience. Avoids jargon and technical phrases.				
5. Materials use language and terms with which the target audience is comfortable.				
6. Use active verbs and short, simple sentences, with one concept per sentence in short paragraphs.				
7. Materials avoid or define difficult words and concepts. Examples are used to clarify.				
8. Use terms consistently (e.g., "HIV" and "AIDS virus" are not used interchangeably).				
9. Materials are straightforward and clear. (Do not use abbreviations, acronyms, euphemisms, symbolism, statistics, or anything else that could cause confusion.)				
10. Text uses line drawings if illustrations are included.				
11. Illustration of anatomy shows position of organs within the whole body (gives relative size and location reference).				
12. Text uses lists, bullets, or illustrations instead of long discussions. Visuals (overheads, slides) are used to emphasize key points.				
13. Text is underlined, boldfaced, or "boxed" for reinforcement.				
COMMENTS:				
14. The text dispels myths, uses acceptable channels, refers to value systems for reasons to change behavior or adopt a new perspective.				
15. Materials provide a call for action.				
16. The text illustrates manual skills from audience perspective.				
17. The text provides reasons for changing behavior.				
18. Materials provide current and accurate medical information.				
19. Materials do not contain sexual preference or racial, gender, or ethnic bias.				
20. Text offers alternative behaviors to the one(s) that put a person at risk.				
21. Realistic and relevant examples are given.				

22. The format of the text is not visually distracting: a. Small type (less than 10 point) is not used. b. Sentences are neither too short nor too long. c. Text does not contain larger blocks of print. d. Right margins are justified. e. Only photographs that are reproducible are included.* f. Only professional-quality drawings are included. g. Technical diagrams are avoided.				
23. Graphics are immediately identifiable, relevant, and simple. They reinforce the text.				
COMMENTS:				

MULTICULTURAL IMPLICATIONS

MATERIAL REVIEW CHECKLIST	EXCELLENT	FULLY/VERY SUCCESSFUL	NEEDS ATTN	N/A
24. Multicultural emphasis				
25. Appropriateness of multicultural activities				
26. Appropriateness of multicultural objectives				
27. Appropriateness of multicultural content				

PLEASE IDENTIFY STRENGTHS OF THE PROGRAM:

PLEASE IDENTIFY WEAKNESSES OF THE PROGRAM:

DO YOU BELIEVE A NEED EXISTS TO BE REQUIRED FOR ALL CERTIFIED AMERICAN RED CROSS AFRICAN AMERICAN HIV/AIDS INSTRUCTORS?

COMMENTS ON CONCLUSION:

GROUP RESPONSE TO FACILITATOR:

OVERALL SUGGESTIONS AND REMARKS:

APPENDIX B

INSTITUTIONAL REVIEW BOARD

APPROVAL FORM

APPENDIX C

RED CROSS PERMISSION LETTER

American Red Cross
of Central Oklahoma
601 Northeast 6th Street
Oklahoma City, Oklahoma 73104-6209
(405) 232-7121 Fax: (405) 236-5691
http://www.redcross.org/ok/okc

September 15, 1999

Marcia Wilson
1717 NE 53rd
Oklahoma City, OK 73111

Dear Marcia Wilson,

This letter is to certify that Marcia Wilson has been given permission to speak to the African American HIV instructor class at the American Red Cross Sooner State Training Institute. The administrator (Heidi Ruster) and the Instructor Trainer have stated that Marcia can come in to the class and speak to and request information for the students.

Sincerely,

Heidi D. R

Heidi Ruster, Assistant Director of Operations and Training

APPENDIX D

CONSENT FORM AND LETTERS REQUESTING PARTICIPATION

CONSENT FORM

"I, _____, hereby agree to participate in Marsha Kay Wilson's descriptive study entitled 'A descriptive Study of The Perceived Values of the American Red Cross African American HIV/AIDS Instructor's Training Course.' Additionally, I agree to complete the questionnaire and submit it to the investigator for the purpose of this study."

"I understand that my participation is voluntary and confidential. I understand that I will not receive benefits for my participation. Additionally, I understand that I may withdraw my participation without any penalty. I also understand that I will not be harmed in any way."

"I understand that I may request permission to see the results of this study."

"I also understand that the information that I provide will benefit society and will provide information regarding how to decrease the incidence of HIV/AIDS in the African American population."

"I understand that I may contact Oklahoma State University-University of Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078: Telephone number (405) 744-5700."

"I have read and fully understand this consent form. I am signing it voluntarily. A copy of the consent form will be given to me after I sign it."

DATE:_____

TIME:_____

SIGNATURE:_____

"I certify that I have fully explained the components of this form to the participant before the participant was asked to sign the form."

SIGNATURE:_____

Letter 1.doc

May 10, 2000

<<FIRST NAME>> <<LAST NAME>>
<<PERMANENT ADDRESS>>
<<CITY>>, <<ST>> <<ZIP>>

Dear <<FIRST NAME>>:

We need your help! I am Marsha Wilson, M.Ed., Oklahoma State University Doctoral Candidate. I am working with the American Red Cross to conduct a study of the American Red Cross African American HIV/AIDS Instructor's Training Course. I graduated from this training course several years ago. As a graduate of this program, your input will be invaluable.

As an American Red Cross Volunteer, you are being requested to take a few minutes to complete the enclosed survey regarding the African American HIV/AIDS Instructor's Course. The information you provide will be compiled and used as data for recommendations for program improvement.

Please be advised the information you provide will be confidential. The survey does not require you to indicate your name. For your privacy, the envelopes have not been coded to identify you by your name. We hope this will facilitate honest responses for the purpose of program development.

If all trainers do not respond, all trainers will receive a second letter of request for participation. Please be advised your response is time sensitive. Please complete and return by May 19, 2000.

If you have any questions, please do not hesitate to contact Marsha Wilson, Research Project Coordinator, at 521-5459 (work), 419-9994 (home) or 560-0691 (pager). Thank you, in advance for your cooperation and participation. We hope to hear from you soon.

Respectfully,

Marsha Kay Wilson, M.Ed.
Oklahoma State University
Doctoral Candidate

Dr. Reynaldo Martinez, Committee Chair
Oklahoma State University
School of Curriculum and
Educational Leasdership

Letter 2.doc

May 22, 2000

<<FIRST NAME>> <<LAST NAME>>
<<PERMANENT ADDRESS>>
<<CITY>>, <<ST>> <<ZIP>>

Dear <<FIRST NAME>>:

We still need your help! A short time ago, you received a questionnaire about the American Red Cross African American HIV/AIDS Instructor's Training Course. The information you can provide us will be very helpful in improving the training course. We need enough of a return to make the results statistically significant. This is your chance to make a difference to those students who will participate in this training program in the future.

Please take a few moments to complete this questionnaire and return it in the self-addressed, stamped envelope. Remember, your input can make a difference.

Please be advised your response is time sensitive. Please complete and return by May 19, 2000.

If you have any questions, please do not hesitate to contact Marsha Wilson, Research Project Coordinator, at 521-5459 (work), 419-9994 (home) or 560-0691 (pager). Thank you, in advance for your cooperation and participation. We hope to hear from you soon.

Respectfully,

Marsha Kay Wilson, M.Ed.
Oklahoma State University
Doctoral Candidate

Dr. Reynaldo Martinez, Committee Chair
Oklahoma State University
School of Curriculum and
Educational Leadership

APPENDIX E

BACKGROUND QUESTIONNAIRE

Focus Group Background Questionnaire

Date_____

Participant:_____ Gender: M F

Race/Ethnicity_____

Present position_____ How long?_____

Previous work experience: How long?

_____ _____

_____ _____

_____ _____

Education/School: Diploma/Degree/Year:

_____ _____

_____ _____

_____ _____

When did you complete the American Red Cross African American HIV/AIDS training course?_____

VITA

Marsha Kay Wilson

Candidate for the Degree of

Doctor of Education

Thesis: A DESCRIPTIVE STUDY OF THE PERCEIVED VALUES OF THE AMERICAN RED CROSS AFRICAN AMERICAN HIV/AIDS INSTRUCTOR'S TRAINING COURSE

Major Field: Occupational and Adult Education

Biographical:

Education: Graduated from Douglass High School, Oklahoma City, Oklahoma in May 1984; received Bachelor of Science degree in Community Health from Central State University in May 1990; received Master of Education degree from the University of Central Oklahoma in July 1991; completed the requirements for the Doctor of Education degree with a major in Occupational and Adult Education at Oklahoma State University in December 2000.

Professional Experience: Associate Director of Health and Social Welfare, Urban League of Greater Oklahoma City, 1992-1997; Development director and program coordinator, Community Health Centers, Inc., 1998; Adjunct instructor, Department of Health and Physical Education, Oklahoma City University, 1998-1999; Adjunct instructor, Department of Health, Physical Education, Recreation and Dance, 1998-1999; Assistant professor, Department of Health and Physical Education/Oklahoma City University, 1999-2000; Department chair/Assistant professor, Department of Health and Physical Education/Oklahoma City University, May 2000- present.

Professional Memberships: American Alliance for Health, Physical Education, Recreation and Dance, American Association for University Professors, Association for Supervision and Curriculum Development and Oklahoma Association for Health, Physical Education, Recreation and Dance.